California Health and Human Services Agency

Strategic Plan for An Aging California Population

Getting California Ready for the "Baby Boomers"

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CALIFORNIA'S STRATEGIC PLAN FOR AN AGING POPULATION

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I. INTRODUCTION AND BACKGROUND

California is home to nearly four million people over age 65 – the largest older adult population in the nation. This number is expected to more than double over the next several decades as the baby boomers begin reaching this milestone. As the population ages we can expect enormous changes that will sharply affect California's economy, housing, land use, leisure, transportation, health and social services, and public resource allocation. We must not underestimate the magnitude or the lead-time required to prepare for these major demographic changes.

Senate Bill 910 (Ch. 948/99, Vasconcellos) addresses this impending reality. The bill mandated that the California Health and Human Services Agency (CHHS) develop a statewide strategic plan on aging for long term planning purposes (See SB 910 statute in Appendix A.)

To support the plan's development, SB 910 appropriated funding for the University of California to provide information and analysis that specifically included:
1) A survey of existing state governmental resources and programs (Yr. I);
2) A composite profile of California's population (Yr. II); and
3) A plan to create a longitudinal database of Californians (Yr. III).

The University's California Policy Research Center's (CPRC) prepared the majority of background information contained in this plan. A complete list of CPRC working group members is found in Appendix B.

In December of 2002, CHHS began the plan development process. Consistent with the legislation, a Plan Development Task Team was created to advise the Agency in developing recommendations to be included in the strategic plan. Task Team meetings took place over a ten-month period and were co-facilitated by CHHS and the Department of Aging.

The Plan Development Task Team included broad representation from important stakeholder organizations representing a range of older adults needs throughout California, including:

California Commission on Aging
California Council on Gerontology & Geriatrics
AARP
California Assn. of Homes and Services for the Aging
California Association of Health Facilities
California Council of the Alzheimer's Association
CA Assn. of Caregiver Resource Centers
Congress of California Seniors
Grey Panthers
Area Agencies on Aging Council of California
California Senior Legislature
California Association of Area Agencies on Aging (TACC)
California Assisted Living Assn.
California Association for Coordinated Transportation (CalACT)
Senior Worker Advocates' Office
Valley Caregiver Resource Center

Older Women's League
Senate Subcommittee on Aging and Long Term Care

Paratransit, Inc.
Assembly Committee on Aging and Long Term Care

The Task Team also invited representatives from stakeholder organizations, consumer organizations, private business and state department staff to share their specific expertise on topical areas the plan would address. (See Appendix C for Task Team members.)

As the Task Team commenced the planning process (see Appendix D) it was clear that the impact of an aging California will cut across all sectors of our society.

- Business will be affected by a shrinking labor pool from which to draw employees.
- Community-based organizations dealing with education, health and social services will experience a great increase in demand for services and a simultaneous need for volunteers.
- Non-profit organizations advocating for older adults will experience similar workload increases as the issues requiring analysis, advocacy and funding grow.
- Local governments will be challenged by land use, housing and transportation demands, to mention only a few.
- Adult education, community colleges and higher education will be strained to re-train older workers for needed jobs and to train health and human services professionals and paraprofessionals.
- Increased demand for state-and locally funded programs, services, and assistance will confront lawmakers and the electorate alike.

It is the hope of the Plan Development Task Team that these organizations/ agencies will accept a role in implementing needed changes; that they will coordinate and/ or partner with other complimentary organizations, public and private, to move this plan forward. To facilitate this hope, the Task Team suggests sector roles for most recommendations. These are summarized in matrix format in Appendix F.

Over an eleven-month period, the Task Team and experts developed 589 policy and action recommendations in the following areas:

- Influencing Federal Policy
- Economic Security and Work
- Transportation
- Housing Continuum including Assisted Living
- Healthy Aging, including Civic Engagement/Volunteerism and Illness Prevention
- Health and Dental Health
- Alcohol and Medication Overuse
- Mental Health Care
- Long Term Care and Support
- Family and Informal Caregivers
- Data and Data Systems
- Health and Human Services Workforce
- Higher Education
- Hospitals and Clinics
- Technology/Assistive Technology

Recommendations were divided into A (high), B and C priorities; "A" priorities were refined for inclusion into this plan. (For other Plan Development Task Team recommendations see Appendix G.) In early August 2003 the top priority recommendations were posted on CHHS' website and disseminated to the public via e-mail for feedback.

Public hearings on the draft recommendations were held in Fullerton and in Sacramento. Approximately 132 individuals attended the hearings and provided very helpful comments. Dozens of suggestions were also received via e-mail. Public input was incorporated and enhanced the final product.

This strategic plan was developed during a time of significant fiscal constraint at the state level. While the current budget reality inhibits the state's ability to respond to many of these recommendations in the short term, they represent an important blueprint to guide state priority setting in developing an infrastructure capable of responding to a rapidly growing aging society.

A. The Changing Demographics

Excerpts from reports by Andrew Scharlach, Fernando Torres-Gil, and Brian Kaskie[1] *and Ronald Lee, Timothy Miller, and Ryan Douglas Edwards*[2]

The rapid aging of California's population represents a demographic imperative that cannot be ignored. California's population is expected to increase by 172% by 2040, with most of the growth occurring in the coming 20 years. The greatest growth will be among the oldest Californians, those age 85 years and older, whose numbers are projected to grow 200% over that 40 year period. By 2040, the ratio of the elderly to adults under age 65 will have increased by 80%.

The confluence of decreased fertility, expanded longevity, falling mortality, and the redefinition of what it means to be older is creating a unique phenomenon, which some have described as an aging "tsunami." California's sheer size, diversity, and large older adult population make it a barometer of how the nation will grapple with the challenges and opportunities of population aging. Stereotypes about aging are slowly crumbling as attitudes about the aging process and what it means to be old change. Today, people who are in their 60s typically do not consider themselves old, and it is normal to find 70 and 80-year-old individuals, who are active, healthy, and engaged.

According to the 2000 Census, roughly 3.6 million of California's 34 million residents were 65 or older, representing about 11% of the state's overall population, compared to a nationwide average of 13%. This difference between California and the rest of

[1] Andrew Scharlach, Fernando Torres-Gil, Brian Kaskie. *Strategic Planning Framework for an Aging Population*. Berkeley: California Policy Research Center, University of California, 2001.
[2] Ronald Lee, Timothy Miller and Ryan Douglas Edwards. *The Growth and Aging of California's Population: Demographic and Fiscal Projections, Characteristics and Service Needs.* Berkeley: California Policy Research Center, University of California, 2003.

the nation are due in large part to the state's comparatively large numbers of international immigrants, who tend to be younger than the rest of the population and are more apt to be male.

Important shifts in the state's age distribution are predicted for the next 50 years, as mortality rates decline and life expectancy increases. Currently, life expectancy in California is 78.8 years, about one year longer than in the nation as a whole. By 2050, CPRC estimates a 50% probability that life expectancy in California will reach 84.2 years. As a result of this as well as other factors, the state's population age 65 or older is expected to double in 25 years and triple in 50 years. By 2050, the median forecast projects nearly 11 million seniors in the state, the size of the current population under 20.

Continued improvements in health and living standards are expected to reduce the likelihood of disability among individual older persons. However, disabled Californians over 65 will comprise a considerably greater share of the total state population as the population ages and becomes more top-heavy, potentially increasing substantially the demands on the near-elderly population of Californians age 40 through 64.

The number of California households is expected to nearly double by 2050, as population aging reduces the share of children in the population, resulting in smaller average household size and an increasing number of households per capita. The number of nursing-home residents also is expected to nearly double over the next 50 years, although the likelihood of being in a nursing home at any one time is expected to decline by 40% in the next 20 years, with increased utilization of home care, assisted-living facilities, and other residential alternatives.

The problem with presenting a brief, composite socio-demographic profile of California's aging population trends is that it masks the significant differences within these sub-populations in a number of key areas. The diversity of California's current and coming older adult population necessitates a more detailed discussion of these "cross-cutting issues."

Gender

California's gender ratio is skewed toward males at younger ages and females at older ages because of age-specific mortality differences between men and women. Before age 45, the number of males exceeds those of females by about 5%. At older ages the trend reverses dramatically, with females over 65 outnumbering males by 40%. Among those age 90 and over, women outnumber men by nearly three to one.

Our forecasts show a decline in the mortality gap between men and women and a more equal ratio of men and women among the senior population. By 2050, women will outnumber men by just 14% among seniors, and by just 50% among those age 90 and over. This equalization implies a large reduction in the proportions widowed

and the accompanying likelihood of living alone or in an institution, as well as the possibility of some associated reduction in the high poverty rates among elderly women.

Race, Ethnicity and Language

Hispanics and Asian Americans comprise relatively large shares of California's current population, compared with the nation as a whole. Of the state's 34 million residents in 2000, 11 million (almost one-third) identify themselves as Hispanic or Latino, while only about 13% of the nation as a whole is Hispanic. California's Asian-American population is also comparatively large, accounting for around 12% of the state's population but only about 4% of the U.S. population.

California's elderly population will become increasingly Hispanic and Asian American over the foreseeable future as a result of population aging and continued immigration. The fastest-growing ethnic group will be elderly Hispanics, whose numbers will nearly triple in the next 20 years. The slowest-growing ethnic group will be non-Hispanic whites, whose numbers will still increase, but only by 50% during that same period. By 2050, Hispanics will be the largest ethnic group among California seniors.

Although California's senior population will be increasingly foreign-born, the overwhelming majority will be long term residents who have lived in the country at least 30 years. The share of California elders who do not speak English is likely to increase by only a small amount, from 5% today to 6% by 2050, although the number who choose to speak another language at home besides English is likely to increase substantially.

Income, Poverty Work, and Educational Attainment

Elderly Californians in 2000 received average incomes of about $25,500, roughly $3,000 more than their counterparts in the rest of the nation. To the extent that living costs may be higher in California, however, that difference may or may not translate into a higher standard of living. Further, higher average incomes among the state's seniors as a group conceal disparities according to national origin. Those who were born in the U.S. received about $6,000 more income on average in 2000 than did all elders nationwide, while foreign-born elders in California received $6,000 less.

California seniors have lower poverty rates than their counterparts in other states, while children are more impoverished than those elsewhere in the country. However, the past decade has seen increases in poverty at almost all ages in California. Only the oldest cohort saw their poverty rates decline over this period, and only by a percentage point.

Employment status is a key measure of economic well-being among the elderly. In addition to public support programs for the elderly in the U.S., many elderly remain employed or self-employed in order to earn wages and stay active. About 13% of

California seniors are employed, compared to 12% nationally, and about 20% of total elderly income comes from labor earnings.

Social Security comprises only 28% of total elderly income in California compared to 34% nationwide. The difference is attributable to higher interest income and labor income for California seniors, as well as the state's comparatively large population of foreign-born elders, some of whom have never participated in Social Security. Foreign-born seniors also tend to receive much less income from investment and labor earnings than those born in the U.S. Employment rates fall significantly past age 60, due to declining labor-force participation rates. Only a quarter of California seniors age 65 to 69 are employed, and that share falls by half for the next age group.

Economic well-being is tightly linked to educational attainment because education provides skills that make workers more productive. The state's seniors are better educated than their counterparts in the rest of the country. About one-fourth of California seniors have attained a college degree or higher, compared with about one-fifth of seniors in other states.

Over the next 20 years the educational level among seniors is expected to rise, as the percentage with college and advanced degrees increases by about one-half. However, between 2020 to 2050 the proportion of the elderly population with a college degree is projected to increase only slightly, while the proportion lacking a high school diploma actually increases from 20 to 24%. The continued influx of less-educated immigrants is apparently enough to partially offset the overall increase in educational attainment among the elderly. Still, educational attainment across all categories is projected to be higher among seniors in 2050 than it is today.

Disability and Health

The disability profile of older Californians is quite similar to that of older Americans as a whole, averaging at most, one percentage point lower on an age-specific basis.

Nationally, disability rates have been declining as much as 3% per year, reflecting improvements in health and living standards. Assuming that this pattern continues, a decreasing percent of California's older adults can be expected to be or become disabled over the next 50 years. The percentage of older Californians reporting limitations in self-care (e.g., bathing, eating, toileting) is projected to drop from roughly 17% today to about 12% by 2030. The percentage with mild disability (inability to perform less-critical pursuits such as grocery shopping and household chores) is expected to decrease from 4% to about 2%.

Because disability prevalence rises steeply with age and the population will be more concentrated in older ages, the overall numbers of disabled elderly will inch upward after 2030 as the population ages. Moreover, disabled Californians over age 65 will comprise a considerably greater share of the total state population as the population

ages and the “oldest old” cohort, those age 85 and over, increases in size, which may substantially increase the caregiving responsibilities of the cohort age 40–64.

In general, declining disability rates offset much of the expected impact on service needs based on population aging alone. Although there will be a considerably larger number of older adults in the state, and this cohort will include an increasing number of the “oldest old,” they will also be healthier and therefore less needy than many of today’s elderly.

Living Arrangements, Independent and Supportive Housing

Older Californians tend to live on their own or with a spouse. In 2000, 58% of elders were living with a spouse, 25% were living alone, 14% were living with family members or other persons, and 2.5% were living in a nursing home. Eighty-two percent of non-institutionalized elders owned their own homes, while 18% were renters.

All other things being equal, the older an individual is, the more likely he or she is to be the head of a household, provided that he or she is not institutionalized. The head of household rate for men is higher than it is for women at every age, although women gain significantly after age 65, probably reflecting the prevalence of elderly widowhood.

By 2050, the number of California households is expected to nearly double, as population aging reduces the share of children in the population. The result will be a smaller average household size and an increasing number of households per capita. Homeownership among the elderly will also continue to rise, from nearly 3 million elderly owning homes today to about 9 million by 2050. The percentage of elderly Californians owning their own home is expected to stay relatively steady at about 82%. The share of elders living alone is forecast to rise by 3 percentage points, while the share living with spouses is likely to decline by about the same amount, with about a 1% increase in the number of elders living with other family members.

The number of nursing-home residents in California is expected to nearly double over the next 50 years, from about 90,000 in 2000 to a median estimate of 170,000 in 2050. These projections reflect steep increases in the population at risk, coupled with declining rates of age-specific disability rates. Given increases in the state’s elderly population in general, nursing-home residents are expected to comprise only between 1% and 1.5% of the elderly population by 2020, down from 2.5% today. These reductions are likely to be accompanied by increased utilization of assisted living communities and other residential alternatives.

Urban, Suburban and Rural Considerations

California is one of the nation’s largest states with a diverse landscape. It is urban, suburban and rural. Northern California is sparsely populated, with beautiful but difficult to navigate mountainous regions. The San Francisco Bay Area and the Los Angeles Basin are the state’s two major population centers. More than two-thirds of

the state's residents live in these areas. The Central Valley is one of the world's most abundant agricultural centers and the San Joaquin Valley is becoming the state's third largest older adult population center.

There is great variation in the range and scope of services available in these various areas of the state. Health and social service infrastructure vary with the landscape, as do the type and range of services available in those areas. While many retirees are drawn to the beauty and affordability of many rural areas, such areas often lack the population density to support the transportation, health and social support services they may need in the future.

Projected Service Utilization and Fiscal Implications

A probability model was developed to predict trends in the service needs and expenditures of a growing aging population.[3] The model is based on a "probabilistic" projection method that simulates 10,000 possible futures. This is to overcome the built-in biases of most population projections and inconsistencies in standard demographic assessments of "most likely" futures. The method enables researchers to explore future needs while recognizing the degree of uncertainty associated with the projections.

Applying the model, if the current age distribution of costs remain constant in the future, the purely demographic changes in California's age structure would modestly ease the tax burden in the state over the next 20 years. Although there will be considerably more elderly in the state, and the elderly themselves will be older, they will also be healthier and therefore less needy than they would otherwise be. Moreover, public spending at the state level is primarily directed toward the young, while the state's tax base includes the population of working age and older.

The analysis indicates that average youth is about 2.7 times more costly to the state than the average older person. Furthermore, older adults are net taxpayers at the state level, with only the oldest-old (those over age 85) net recipients of state benefits. However, it is anticipated that the age distribution of these expenditures will change in the future.

These projections indicate that the economic challenges posed by the state's population aging over the next 50 years appear to be manageable. Caseload for state-administered public services for older adults, such as means-tested cash support and medical care for the indigent and medically needy, will certainly grow as the number of elderly residents increases. Per capita medical expenditures will also increase. A substantial growth in the need for all long term care options—from nursing home and assisted living to family and home and community-based supports—is anticipated. Meeting these needs will require refocusing state fiscal policy as the state's population ages.

[3] Ronald Lee and Timothy Miller (2002). "An Approach to Forecasting Health Expenditures, with Application to the US Medicare System." *Health Services Research*, n.5 (October).

B. Redefining Aging Policy

Excerpts from a report by Andrew Scharlach, Fernando Torres-Gil, Brian Kaskie[4]

Three critical aging policy "cornerstones" should guide policymakers in developing a sound foundation for the aging**:**

1. Adapting a Broader, More integrated Perspective

Most of the major aging policy issues that need to be addressed are inter-related. Policymakers and planners can no longer continue to view and address specific topics and concerns discretely. For example, transportation needs are related to the land-use planning that has encouraged suburban living, the expense of developing paratransit systems to meet the needs of older people when they are no longer able to drive, and the lack of affordable housing in urban areas where public transportation is more available.

2. Redefining Who is "Old" and Reconceptualizing Aging Services

The very definition of "old" is apt to change in the coming years, so that becoming age 65 and/or retiring will not determine being old. With changing expectations, chronological age will be questioned as a criterion for public program eligibility. The cohorts that will be age 65 and over in the next 20 to 30 years will be more mobile and healthier. At the same time, large numbers of older adults will continue to be poor, chronically ill, isolated, and in need of public services. Functional ability needs to be considered as a more relevant criterion for program eligibility. Thus, in addition to redefining aging, policymakers need to account for the diversity of needs and expectations among future cohorts of older people in order to use state resources wisely and plan effectively

3. Rethinking Retirement

Traditional notions of retirement are becoming outmoded. The combination of early departure from the labor force (by choice or ill health) and an increased life span means that some people are spending more years in retirement. Many more will continue working into their 70s and 80s because of choice or inadequate retirement savings.

The manner in which retirement is promoted and pension plans are structured needs to be modified, given the shifting climate of retirement and pension expectations. As a society we also need to find ways to better integrate the increasing numbers of older Californians into the lives of their communities. This will enhance opportunities to be useful and relevant, and provide a rich and largely untapped resource for civic involvement in the state. Retirees have the potential to mentor, volunteer, or pursue rewarding second careers that will benefit themselves, their communities, and the economy.

[4] Scharlach, Torres-Gil, Kaskie. *Strategic Planning Framework*. Pages vii-ix.

CROSS CUTTING POLICY IMPERATIVES [5]

Providing an Adequate Infrastructure
California's current ability to provide health and mental health care, social services, safe housing and transportation is inadequate, and much work is needed to prepare for the future. Significant investments have been made in expanding home and community-based support options. Today 92% of Medi-Cal beneficiaries receive long term support in the community. Half of all Medi-Cal Long Term Care (LTC) expenditures is for institutional care.

Affordable housing for California's older adults is dwindling, especially as federal subsidized units are converted to market-rate rents. In some counties, rents for a studio apartment exceed the average monthly SSI/SSP payment. African American and Latino elders are more likely than non-Latino whites to live in substandard housing and experience severe economic burdens related to housing.

Reducing Economic Disparities
The increasing gap between those who are well off and those who are not is one of the greatest challenges we face. While many Californians will grow old with assets, pensions, health care coverage, home equity and good health, many others will face old age with the specter of poverty, poor health and isolation. These older people – limited English speakers, people with inadequate education who had worked in low-skill jobs, single women and those without retirement pensions or their own homes – may be most dependent on public programs. Effective strategies are needed to reduce or ameliorate inequities in well-being and ensure that older Californians have access to available resources.

Promoting Opportunities for Older People
California needs to address age discrimination, which continues to bar full labor-force participation among workers over the age of 50. Tapping the rich experiences and skills of the state's retirees will help older people stay involved with and contribute to their communities, while also increasing their physical and mental well-being and quality of life.

Training may be required for some older adults, especially for immigrants and others who are apt to lack the education and technological skills to participate in the new economy. Accommodations may be required for others who have disabilities of various kinds. Nongovernmental organizations could play a significant role in training and employing older people.

Promoting Planning and Coordination
The state has made great progress in LTC planning with the establishment of the Long term Care Council that requires relevant department directors to work together to address the health, mental health, rehabilitation, long term support, housing and

[5] Scharlach, Torres-Gil, Kaskie. *Strategic Planning Framework*. Pages ix-xi.

transportation needs of persons with disabilities. This type of inter-departmental planning and collaboration must be encouraged at both the state and local level.

Coordination with federal policymakers is also needed. Current overlaps in funding, target groups, services, oversight and evaluation are often created by federal funding and program requirements, making it difficult to provide adequate and coordinated services. To develop a successful aging policy, state policymakers need to advocate at the federal level, since federal decisions and funding allocations significantly impact the resources available within the state, impacting the economic security and access to a variety of health, employment and social service supports for older adults.

Other levels of government also play crucial roles in meeting the needs of older adults and should be involved in regional strategic planning. Counties and cities are on the front line in serving older people. Counties provide vital health and social services, while cities handle public safety, land-use, transportation and housing programs. Both rely on a combination of federal, state, and local resources to fund these programs and to operate their local Area Agencies on Aging.
Without coordinated efforts, it will be difficult to promote a comprehensive statewide approach. These efforts need to involve the private, nonprofit, and philanthropic sectors as well.

Improving Information
Despite a wealth of information available about population and individual aging, great gaps in data affect our ability to accurately assess California's needs, trends, and characteristics. The state needs to develop a comprehensive, longitudinal database that tracks population characteristics and needs as well as the effect of major policy and program initiatives.

Educating and Involving the Public
Preparing for an aging California requires leadership and a campaign to inform the public that they must rethink how they prepare for their retirement and old age. A "longevity" campaign would ask the question: "What would you do differently if you knew you would reach 100 years of age?" This campaign could include a scorecard by which the public could track their preparations for retirement, disability, long term care, lifelong learning and all that is necessary to enjoy a high quality of life in the later years.

All of these efforts present enormous challenges and multiple opportunities for leadership and vision. Although California's Secretary of Health and Human Services is mandated to lead the process of developing a strategic plan, the state's ability to prepare for an aging population will depend on creative, innovative effort by people in all sectors of society: elected and appointed officials, advocates, scholars, service providers, community representatives and older adults themselves.

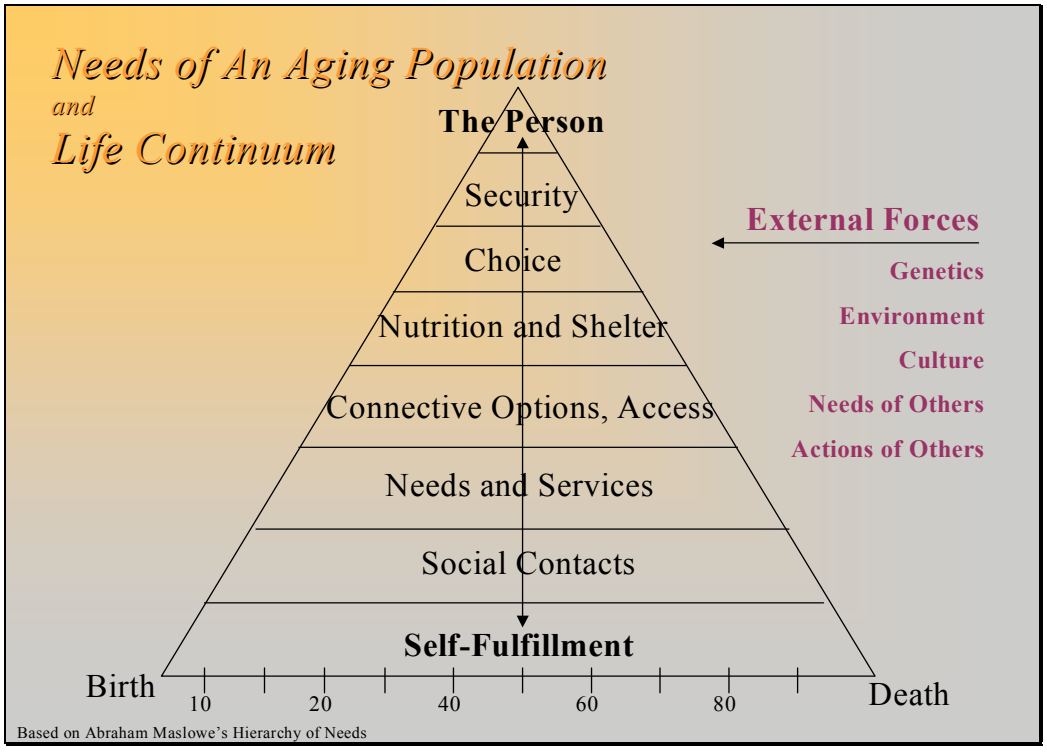
C. Overarching Principles

In designing a strategic plan to address the aging of California's population, two essential principles must be taken into consideration.

The first is that aging is a "life long process." The overall well-being of an older adult is in large part shaped by his or her access to and use of public and personal health, mental health, social supports, educational opportunities, employment/income and more over the course of a lifespan. Societal investments that impact the population at all ages significantly shape the aging experience. For example, the overall public health improvements in sanitation and childhood mortality that occurred in the early 20th century had a profound impact on the number of adults living to achieve an old age. Investments in K-12 and post secondary education reduce the risk of developing dementia in late life.

Formulating a comprehensive set of recommendations covering the lifespan would be an immense undertaking well beyond the scope of this legislative mandate. This plan's recommendations, therefore, are primarily targeted to interventions for the older adult population.

The second principle, based on the work of psychologist Abraham Maslowe, is that human needs have a certain hierarchy.[6] If certain fundamental needs are not met



[6] Abraham Maslowe. *A Theory of Human Motivation*. Psychology Review 50, July 1943. Pages 370-396. For complete discussion: *Motivation and Personality*. New York: Harper, 1954

it is difficult to focus on the next level of personal growth. Maslowe's concept is the basis for the model above, which was used to recognize and organize the issues required to address the needs of California's aging population.

At the top of the modified pyramid is the person; at the base is self-fulfillment. A two-way arrow runs from end to end. The downward track represents an individual's growth or attainment of various levels of need toward self-esteem and self-fulfillment. The upward arrow represents movement away from self-fulfillment.

Starting from the top, the person's security needs must be met; these can include income security, physical security and freedom from fear of abuse.

The next level of need is choice. Older adults should have an array of choices including where they live, how they travel from place to place, what they purchase, and with whom they spend time.

Next are food and shelter, without which security is lost. Food choices can result in malnutrition and/or obesity. "We are what we eat." Providing meals may be crucial for those who would not eat without them. Nutrition education can help many live longer lives. Housing choices are made from a continuum of options: from independent living, living independently with supports, to assisted living, or skilled nursing facilities. The focus is on maintaining the greatest freedom possible.

After food and shelter, older adults need connective options - for visits with family and friends, to obtain services and shop, for emergencies and more. Individuals may connect by phone or the Internet, by walking or driving or by public transportation. It is essential that there is a range of choices to satisfy a diverse population.

Service choices will be different for everyone. In the context of this plan it is important that services are accessible and plentiful, especially as people become more vulnerable. The availability of supportive services may mean the difference between having choices or not, between living in the least or most restrictive environment.

Meaningful social relationships - being loved, needed and connected to one's community - give people's lives meaning. Recommendations on volunteerism, transportation, livable communities, intergenerational activities and caregiving support this need.

Fulfilling one's needs enables older adults to live secure, self-fulfilled lives. However, as the diagram above indicates, there are external forces that impact an individuals' ability to meet their needs. These include geographical location, racial and ethnic inequities, as well as the actions and needs of others.

This Strategic Plan for an Aging Population attempts to address these issues.

D. Budget Constraints

Due to the current fiscal condition of this state, the need for additional resources presents a significant challenge to implementation of some Plan recommendations. This Plan suggests actions that can and should be taken by all sectors, public, private, non-profit, that impact or will be impacted by the older population. However, recommended policy and action that is the sole responsibility of the state will need to be delayed until alternative funding can be obtained or until the fiscal condition of the state improves. These are specifically identified in this Plan.

In addition, there is no guarantee the state's leaders will appropriate the necessary funds for these activities even with an improved fiscal climate. However, there are important activities that might move forward with a re-direction or alternate use of resources or with better coordination and collaboration among existing programs. Even the completion of these activities may be delayed if existing resources are further reduced due to budget constraints.

II. THE PLAN - VISION, POLICY, ACTION

A. Influencing Federal Policy

BACKGROUND

Many of the major income supports that impact the lives of older Californians are either federal health and social service programs or are regulated by federal statute. Major examples include Medicare, Social Security, the regulation of pension benefits, and supports for low income individuals and families, such as Supplemental Security Income (SSI), Housing and Urban Development (HUD) Section 8 and 202 housing, Medicaid (Medi-Cal) programs. While states may have some role and flexibility in administering these programs, the state's funding appropriation plus the regulation and guidelines are established at the federal level.

The implications of federal policy decisions can have a significantly different impact on a state like California than in other areas of the country. For example, changes in payments to Medicare drove most managed care plan options out of California's rural areas and out of some suburban and urban areas as well. As a state with a disproportionately higher Medicare managed care enrollment, both California's residents and many health care providers were negatively impacted by this policy decision. To prevent similar consequences of federal policy it is imperative that state policymakers intervene at the federal level through all channels available to them to advocate on behalf of policies and funding strategies that will benefit older Californians.

FEDERAL RECOMMENDATIONS

Through the National Association of Governors, the National Association of State Legislators and the White House Conference on Aging, the state should advocate for the following:

1. ECONOMIC SECURITY

a. Continue current SSI benefits that include predetermined cost of living adjustments (COLA), so that older participants receive sufficient income to close the poverty gap. Efforts should also be taken to increase outreach to those who are eligible for SSI and expand enrollment to get a greater number of older adults in poverty into the program.

b. Strengthen Federal laws prohibiting age discrimination and establish a genuine system of enforcement.

2. JOBS FOR SENIORS

a. Create incentives for employers to retain and hire older workers and for older workers who may be pursuing jobs at the low end of the pay scale.

1) Create a Federal Tax Credit for hiring persons over age 50 to help reduce the cost of hiring older adults.

b. Abolish Workforce Investment Act (WIA) Disincentives - Urge the Federal Government, Secretary of Labor, to assess the impact of WIA performance measures on older workers and adjust them to eliminate disincentives to enrolling older workers in programs funded by the WIA.

3. HOUSING

a. Expand Housing and Urban Development (HUD) rental assistance programs so that more eligible households/individuals can access affordable housing.

b. Maintain the current 30% cap of income that an individual with a rent subsidy must pay.

c. Ensure a fair share of senior housing in the administration of the Housing and Emergency Shelter Trust Fund Act of 2002

d. Maintain and increase continued funding commitments to the Public Housing Program, Section 202 Senior Housing Program, the Section 515 Rural Housing Program and programs for keeping housing in adequate condition.

e. Preserve/renew federally subsidized housing programs that have expiring contracts.

4. TRANSPORTATION

a. Increase annual appropriations and authorization levels for Federal programs that serve rural and urban elderly and disabled populations. These include Federal Transit Administration (FTA) Section 5310 and Section 5311 programs. Efforts need to be continuous.

b. Establish new federal funding sources for operating and capital costs for innovative accessible alternatives to fixed route and rail transit services.

5. ALCOHOL AND CHEMICAL DEPENDENCY

a. Develop funding for alcohol and chemical dependency education and awareness campaigns targeted to seniors. Include screening and referral.

b. Eliminate funding inequity for substance abuse treatment in Medicare and other health insurance programs to ensure that program beneficiaries have access to needed treatment options.

6. HEALTH CARE

a. Establish a comprehensive Medicare prescription drug benefit.

7. MENTAL HEALTH

a. Eliminate funding inequity for mental health services in the Medicare program.

b. Advocate a shift in Medicare policy to recognize “functional necessity” and treat the *whole* person vs. current concepts of “medical necessity” and “progressive improvement.”

c. Resolve discrepancies between the Medicare fiscal intermediary and individual service providers so that persons who move from one region of the country to another can be assured of the portability of their coverage/benefits.

8. LONG TERM CARE FUNDING

a. Increase Federal appropriations for critical Older Americans Act services including Title III-E (caregiver support programs) in proportion to the increase in the older adult population.

b. Increase funding for and the quality of nursing facility monitoring.

c. Explore the viability of increasing the federal match for Medicaid long term care services or, alternatively, move responsibility for this support to the federal government for nursing facility services, through a Medicare Part C concept.

9. TECHNOLOGY

a. Encourage Medicare and Medicaid reimbursement of telemedicine services, especially for mental health services.

10. HEALTHCARE WORKFORCE

a. Expand Medicare provider reimbursement to include patient counseling and more in-depth examinations to attract physicians willing to take on heavy geriatric caseloads or to specialize in geriatrics.

b. Establish a palliative academic career award to support education in the fields of geriatric and palliative medicine. This should be similar to the existing Geriatric Academic Career Award (GACA) now administered by the Health Resources and Services Administration (HRSA).

B. Economic Security and Work

BACKGROUND

Economic Well-Being

Excerpts from a report by Kathleen McGarry and Brian Kaskie [7]

Older adults have experienced substantial growth in the level of their economic well-being over the last 50 years. The poverty rate has been significantly reduced [with a corresponding increase] in total wealth. [Since 2001, however, the steep decline in the stock market and the concurrent reduction of IRA, 401K and similar retirement plans have eroded these gains. Furthermore, gains] have not been experienced by every person over the age of 65. Older females and individuals from nonwhite racial groups were two to three times as likely to be impoverished. The assets of nonwhite older adults were less than half of older whites, and these individuals hold a smaller amount of total wealth. In fact, the richest 10% of the older adult population had amassed a total wealth that is 45 times higher than the poorest 10%.

These variations in economic well-being are related to disparities in retirement income and asset accumulation. Payment of Social Security benefits varied by racial status and also by the lifetime level of earnings. The provision of pension income also varied by racial group, as white older adults were more likely to receive pension income than African-American or Hispanic older adults. The provision of Supplemental Security Income was provided to nearly 300,000 older Californians as a way to improve economic well-being among the most poor, but there were almost as many individuals who would qualify for the program that were not enrolled.

Whether or not the disparities in economic well-being will persist over the next 20 years remains uncertain, and whether or not the level of well-being experienced by the current cohort of older adults continues for the coming generations remains in doubt as well. As the older adult population becomes increasingly diverse, the State of California should address the protection of the most basic level of economic well-being for the aging population, and consider how to resolve the tremendous disparity that exists within the aging population.

Labor and Retirement Status

Excerpts from a report by Irene Yen and Edward Yelin [8]

Older adults participate in the labor force at a lower rate than younger adults all over the country, and Californians are no exception. Many Californians over the age of 65

[7] Kathleen McGarry and Brian Kaskie. *The Economic Well-Being of Older Californians*. Berkeley: California Policy Research Center, University of California, 2001.

[8] Irene Yen, Edward Yelin. *Labor and Retirement Status of California's Aging Population*. Berkeley: California Policy Research Center, University of California, 2001.

are completely or partially retired. Many of these people left the workforce voluntarily and were provided strong economic incentives to do so.

In 2000, more than 90% of the older population was collecting Social Security and other retirement income and benefits. Another group of older Californians continue to work, some by choice and a growing number due to economic need. According to AARP, "the need for money is the primary motivator"[9] for working in the traditional retirement years. Workers over the age of 62 are more likely to work part time, be self-employed, work at home and work in small firms than younger workers. Gender, race and educational discrepancies in labor-force participation widen with age.

These discrepancies should become even more apparent over the next 20 years, as the new economy evolves. In the new economy, younger workers are less likely to be employed by firms that offer pension coverage and health insurance that benefits retirees, so the need to work to have sufficient retirement income should increase.

Policies and programs are needed that support individuals' continuance in the labor force for as long as they need or want to work. Indeed, many Californians over age 50 indicated that they were partially retired and available for work under appropriate circumstances. The economy could benefit by making circumstances conducive to employment for the approximately 762,000 people over age 50 who are available to work. Training older individuals for second careers would be helpful, as would educating employers about this pool of labor.

THE VISION - In the year 2020…

Income Security

On behalf of its senior population, the State of California has successfully influenced Federal policy to help ensure income security for its residents. This has eliminated/reduced economic disparities, including those that significantly impact older adults who are low-income and often ethnic minorities. All retired Californians know they can rely on the elements of a secure retirement**:** adequate and available health insurance, social security, pension plans and personal savings.

Pension Protection

By 2020, employees enrolled in pension plans are guaranteed that the pension benefits promised to them by their employers are available to them upon retirement.

By 2020, an appreciation of the qualities that older workers bring to the workplace will have ended practices that reduce the value of pensions owed to older workers…workers of all ages will be accorded similar pension benefits without regard to age. Minorities, women and lower wage workers will be increasingly enrolled in pension programs.

[9] *Staying Ahead of the Curve 2003: The AARP Working in Retirement Study*. Data Collected by Roper ASW, report prepared by S. Kathi Brown. Washington DC: AARP Knowledge Management, 2003. Page 6.

Employment

Incentives have produced a genuine win-win situation that has encouraged employers to hire older workers, especially low-income seniors.
Employers have fully implemented pension protection programs that have successfully protected workers from losses such as those that occurred in the early years of the century.

- Thanks to training programs suggested and sponsored by a coalition of businesses, community colleges and community service organizations, employers are using seniors to fill vacant positions that resulted from the lower birth rate years following the baby boom. The success of this trained, motivated and mature workforce has had many results including:
- Employers have more options for filling vacancies and seniors have been able to earn important additional income by having full or part time jobs
- Seniors are working because they want to, at paying jobs or as volunteers in positions that match their ability
- If seniors do need to supplement their income, many employment options are available including full time, part time, flex time and job sharing.
- Age discrimination has vanished from the workplace
- In order to attract workers, employers are offering workers their choice of pensions or 401K type self investment programs

Financial Management

Financial management services, tools and incentives developed by a coalition of California employers, financial services sector and educators have helped all Californians to save through an expanded array of savings and investment options.

Financial planners are more in tune with the needs of seniors due to the Financial Planner Certification now requiring special courses on the financial needs of seniors.

Californians are now much better prepared for their retirement due financial management classes offered by employers and available through adult education and a variety of post secondary educational settings.

Abuse Prevention

Due to the statewide campaign to identify and prevent elder abuse and the implementation of improved fraud hot lines, abuse has been greatly reduced.

- There is a mindset of respect and appreciation for seniors.
- There is reduced mental and physical abuse.
- K-12 elder abuse awareness programs are now being taught by seniors.
- Due to the senior education programs and the public awareness campaign, financial abuse by families and acquaintances has dropped significantly.
- Mail and telemarketing fraud has also been greatly reduced.

RECOMMENDATIONS

ECONOMIC SECURITY

1. Insurance: Health, Supplemental, Long Term Care

a. Close the Retirement Eligibility Gap. Increase options for health insurance coverage between retirement and Medicare eligibility. [10]

b. Increase the number of Californians who have private long term care (LTC) insurance.

1) Explore the formation of large-group risk pooling to achieve lower per-capita group rates and more universal coverage.

2) Employers should be encouraged to expand benefit menu options to include long term care insurance.

2. Protect Pension Income

a. Review the impact of *defined contribution pension plans* on older adults' ability to retire with sufficient income. [11]

b. Steps should be taken to increase the enrollment of persons with disabilities and minority populations into pension programs and to encourage employers to provide such plans.[12]

3. Asset Protection

a. Personal Contribution - Older adults should be expected to spend a reasonable amount of their total wealth on their own consumption and to be responsible and self-sufficient. Other than for home and automobile, policies should not protect the assets of those individuals who consume a substantial amount of services or benefits.[13]

4. Dispute Protection

a. Develop protections for patients in the event of hospital and/ or health plan disputes.

WORK, JOBS

1. Provide Job Training and Supports for Job Seekers

a. Consolidate and revitalize private non-profit and community based organizations' older worker programs.

1) Eliminate service fragmentation and add an older worker advocacy component

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[10] Yen, Yelin. Labor and Retirement Status of California's Older Population, page 14

[11] McGarry, Kaskie. The Economic Well-Being of Older Californians, page 11

[12] McGarry, Kaskie. The Economic Well-Being of Older Californians, page 11

[13] McGarry, Kaskie. The Economic Well-Being of Older Californians, page 11

2) Provide culturally relevant, job-related supportive services for older workers including: personal and job counseling, job referral services, resumes/job applications and supportive services, including interviewing skills and transportation, health management and appropriate supports for persons with disabilities.

3) Establish or revitalize job development relationships with business and labor.

4) Coordinate relationships with educational institutions to provide appropriate opportunities for career enhancement, job training, retraining and skill development.

b. Community College/Adult Education Job Support Programs

1) Implement senior curriculum and services through the Community College system that will provide an array of educational and counseling options to help California's older residents enhance their skills and therefore, their opportunities to find and keep jobs.[14]

c. CSU and University of California Job Support Programs

1) Offer Extension courses that meet the needs of older working students who need to upgrade skills and/or participate in certificate programs in order to enhance career change/employment options.

2) Expand offerings over the Internet, grant work/life credits toward earning a degree, and similar creative methods to support the continuing education needs of the aging workforce.

d. Employers develop/provide internal career coaching, mentoring development programs.

2. Jobs

a. Flexible Work Options

Employers should develop mechanisms for improved work options including flexible scheduling, compressed work week, job sharing, part time/on call employment, "V-time" or voluntarily taking a portion of the year off, and telecommuting. Provide incentives by offering prorated health benefits to part-time employees.

b. Employment Navigator Program

Monitor state Employment Development Department (EDD) pilot project. If successful, consider expanding the model to help seniors and persons with disabilities who want to work. The Employment Navigator helps individuals sort through their needs to find work that will not adversely impact their benefits.

c. Take Action to Eliminate Age Discrimination

1) Change negative stereotypes of aging that exist in the media and throughout society by incorporating issues of diversity and elder involvement into the Stay Well public information program and on the Industry Coalition on Age Equity and the Media (ICAEM) agenda.[15]

2) Strengthen and reinforce current employment law with regard to age discrimination. Include:

[14] Yen, Yelin. Labor and Retirement Status of California's Aging Population, page 14

[15] Also called for in Senate Bill 953 – California Integrated Elder Care and Involvement Act (2002, Vasconcellos)

Expansion of employers awareness of the law

- Clarification of whom enforces the law, strengthen enforcement procedures
- Strengthening of enforcement accountability and consequences
- Strengthening of rights of employees
- Clarification and simplification of how employees file complaints

3) Workforce Investment Act (WIA) Disincentives - Urge the Federal Government, Secretary of Labor, to assess the impact of Workforce WIA performance measures on older workers and adjust them to eliminate disincentives to enrolling older workers in programs funded by the WIA.

d. Enrich/maintain EDD Job Networking Programs

1) In coordination with the state EDD, expand "Job Clubs" in One Stop Centers. Job Clubs are voluntary networking associations helping workers find employment.

2) Job seekers in professional, technological, and managerial occupations should take advantage of EDD-sponsored "Experience Unlimited" chapters.

e. Employers should provide training to managers and supervisors on interacting with adults with disabilities.

ABUSE PREVENTION

1. Expand Abuse Hot Line

a. Review options for expanding the Attorney General's Abuse Hot Line program (888-436-3600), which addresses financial abuse and fraud, to include reporting of physical and psychological abuse, predatory lenders and neglect in community settings.

2. Coordinate Resources

a. Develop a statewide process to effectively coordinate existing local, state and federal resources to address elder abuse. Ensure that law enforcement and prosecutors involved in the system are aware of the laws, have the necessary specialized training and are working together to bring cases to trial.

3. Peace Officer Training

a. Add a course to the basic Peace Officer Standards and Training (POST) curriculum on how to recognize physically and mentally abused elders, and patterns of elder abuse in families and communities. This training should also include abuse of persons with disabilities.

b. Provide funding for elder abuse prevention and intervention.

1) Provide funding for Adult Protective Services in order to ensure protection of one of California's most vulnerable populations from theft, neglect and abuse.

2) Encourage local government to maintain funding for adult protective services, elder abuse investigators and prosecutors.

4. Caregiver and Provider Training

a. Incorporate elder abuse awareness in continuing education and training for caregivers at all levels.

AGING AWARENESS CAMPAIGN[16]

1. Recommendation: Develop and implement a statewide public awareness campaign to:

a. Promote habits that will enhance successful aging

b. Focus on the actual and potential contribution of the senior population to society

c. Deal with issues such as elder abuse and other cross-cutting issues.

[16] Also called for in SB953 (2002, Vasconcellos).

C. Transportation

BACKGROUND

The needs of older travelers are similar to the needs of all travelers**:** [17]

Service Attributes	Most Important Feature	Other Important Features
Acceptable	Reliability	Comfort
Accessible	Proximity (door to door)	Ease of use
Adaptable	Flexible	Assistance with special needs
Available	Responsiveness/frequency	Hours/days of service
Affordable	Low fare	Discounts/subsidies if needed
Adequate	Area wide	Inter and intra regional service
Alternative	Choices	Supplemental services

Transportation and Mobility
Excerpts from a report by Martin Wachs [18]

Mobility is critical to the well-being of California's elderly. To live full lives and avoid social isolation, people must be able to access friends and relatives, health care services, shopping opportunities, and social and recreational activities. Older Californians are the most automobile dependent group in our society, making well over 90% of all their trips in automobiles, either as drivers or as passengers. Over time, the elderly are becoming ever more automobile oriented, and an increasing proportion of them live in communities in which it is difficult to reach their destinations by transit and walking.

While most older adults are safe drivers, advancing age reduces vision and hearing and increases response time. Involvement in vehicle and pedestrian accidents increases with age, and society must balance the costs and benefits of restricting driving among older adults with functional limitations against those of encouraging a mobile older population. License removal and driving restrictions are often favored to ensure the safety and well-being of the population, yet many authorities are reluctant to reduce the mobility of the aging population. Graduated licensing is a possible approach for dealing with gradually declining driving skills. Research shows that the testing older adult visual acuity and written driving tests are poor predictors of safe driving among the elderly. Furthermore, while it is difficult to oppose educational programs to help older drivers and pedestrians learn more about their circumstances and conditions, there is little evidence that such training improves safety. For these

[17] *Improving Public Transit Options for Older Persons.* Washington, DC: Transit Cooperative Research Program (TCRP) Report 82. Prepared by WESTAT for the TCRP administered by the Transportation Research Board. May, 2002
[18] Martin Wachs. *Mobility, Travel and Aging in California*. California Policy Research Center, University of California, 2001.

reasons, the testing and licensing of older adults creates challenging dilemmas for policymakers.

Older adults are at risk of becoming clinically depressed as a result of no longer driving. To address this "isolation anxiety" programs are needed to help those who decide to stop driving make the transition. Pre-cessation planning and educational techniques must be developed to identify and test strategies to help drivers cope before, during, and after driving cessation. Research should be conducted on the practical economic, social, psychological and physical consequences of driving cessation or reduction. Transportation systems need to provide more mobility alternatives and need to be routinely assessed to ensure they are meeting the full transportation needs of the communities they serve.[19]

Public transit can be improved through the provision of more accessible vehicles, reduced fares for senior citizens, and wider service areas. In some communities volunteers provide older citizens with rides to and from their activities. In other areas, paratransit services are provided to serve many of the transportation needs of older persons and persons with disabilities. Paratransit services are specialized van and bus services that bring clients to particular service centers and facilities. For purposes of this Plan, paratransit is synonymous with social service and human service transportation. In the long term, hopefully communities will include a richer mix of commercial and service activities in proximity to residential neighborhoods, by increasing densities, and by making neighborhoods more walkable and more friendly to cycling. Despite these goals, most older adults are expected to continue to make most of their trips in automobiles driven by themselves and their close relatives and friends.

Improvements to highways, such as larger letters on signs and sharper edge delineation have helped older driver safety, and should be incorporated into public policy. Vehicle technology is also changing in ways that can aid older drivers. Vehicles can be made easier to drive by older people, for example, through the use of night vision windshields, and vehicles can be made safer by designing restraint systems and interiors that are more compatible with the physical characteristics of older drivers and passengers.

THE VISION - In the year 2020…

Transportation is an essential part of the community planning process. Ironically the transition from building-focused planning without regard to connecting residents to jobs and services has stimulated a building boom in higher density, affordable housing close to, or built with, support services and transit stops.

[19] David R. Ragland, Ph.D., M.P.H.- UC Traffic Safety Center, William A. Satariano, Ph.D., M.P.H.- UCB School of Public Health, Kara E. MacLeod, M.A.- UC Traffic Center. *Driving and Increased Depressive Symptoms*. University of California at Berkeley, 2003. Pages 9-11.

Shopping, recreational and even health services are within easy walking distance. Older adults (and other age groups) are leaving their cars at home and improving their fitness as a result.

The California Mobility Council, formerly the Mobility Task Force, is responsible for dramatic improvement in transportation options for seniors and all Californians. The Mobility Task Force developed and oversaw the implementation of the California Coordinated Transportation Services Program. This became a continuum of cooperation, funding and service delivery among state, regional and local programs – both government and community based.

In proportion to the population, there are fewer cars on the roads due to clean, safe, senior-friendly and accessible transit systems. As with many changes intended to support seniors who do not choose to drive, the population at large is enjoying the benefits and is now using mass transit like never before.

Various incentives have significantly increased the production of accessible vehicles including cars, vans and low platform buses. Consumer pressure increased the production and modification of vehicles with features such as night vision windshields and senior-friendly interiors and restraint systems. Manufacturers and modifiers find this to be a very profitable business.

With improved rural public transportation, subsidized taxi service and, when necessary, well-managed and customer-friendly paratransit systems, seniors in rural areas and individuals with disabilities can now easily get to where they need or choose to go at any time, day or night.

Driver Safety Statistics have improved and older drivers no longer have high per mile driven accident rates. This accomplishment is due in part to the greater use of public transit, and also due to research that led to:

- Safer road design and signage
- Safer vehicle design
- Effective older driver risk identification and risk reduction
- Equitable driver risk assessment and licensing practices
- Training specifically matched to the driver's functional needs

Federal Block Grants, Transit Administration funds, and state funds were increased and continuing commitments were secured. There are now reliable resources for state and local transportation programs.

TRANSPORTATION RECOMMENDATIONS

TRANSPORTATION SERVICES

1. Create Mobility Management Centers[20]

a. Implement Mobility Management Centers to connect people to a continuum of accessible transit services. These can include:

1) Fixed route bus and rail services for healthy, independent travelers
2) Service routes, route deviation and flex routes for persons with some mobility limitations
3) Paratransit services for persons unable to use fixed route bus and rail systems
4) Escorted services for frail travelers and persons needing special assistance
5) Medical and emergency services for those with critical needs
6) Discounts, subsidized service with authorization by the issuing service agency

b. These Centers would include Mobility Training Programs to familiarize riders with appropriate transit mode, reserving paratransit, escorted and medical services as safety net modes, rather than as a first choice.

c. Subject to the availability of funds, Area Agencies on Aging (AAAs) should assign a staff person the role of Transportation Coordinator, acting as a liaison to the Mobility Management Center.

d. Elevate Regional Center Transportation Coordinators to full time positions with adequate resources.

e. Attach "mobility management centers" to Consolidated Transportation Services Agencies (CTSA). Where CTSAs do not currently exist, Regional Transportation Planning Agencies and Local Transportation Commissions should be required to make such designations pursuant to the Social Service Transportation Improvement Act (AB 120, 1979)

2. Create a California Mobility Council

a. Subject to available resources, develop a California Mobility Council to become the organization responsible for removing barriers between programs, monitoring performance, ensuring communication and cooperation among Mobility Management Centers, and adapting state policy as needed.

b. Suggestions for representation on the Mobility Council could include:

1) Business, Transportation and Housing Agency (California Department of Transportation, California Highway Patrol, Dept. of Motor Vehicles)
2) Health and Human Services Agency (Departments of Aging, Rehabilitation, Developmental Services, Health Services, Mental Health and Social Services)
3) Suggested advisory counsel members:

[20] Mobility Management Centers function at the local and regional levels to identify, inventory, and match riders with services.

- The California Association for Coordinated Transportation
- The California Transit Association
- The California Commission on Aging
- The State Independent Living Council
- And other appropriate agencies or departments

c. Suggested Mobility Council responsibilities would include:

1) Providing direction, oversight and policy guidance to health and human service agency operators and transportation providers to maximize coordination of transportation services

2) Enforcing federal regulations that call for coordination among federally supported transportation programs

3) Identifying and quantifying current state administered spending for transportation by older adults

4) Developing a system to collect uniform data on transportation services for older people and persons with disabilities

5) Identifying ways in which existing funding can be used more effectively and the need for additional resources

6) Establishing cost-sharing guidelines that encourage human service providers and public transportation agencies to pool resources

7) Recommending meaningful incentives or mandates in which health, human service and local transportation agencies would participate

8) Monitoring unmet transportation needs identified in the needs assessments conducted by Area Agencies on Aging and included in their area plan and reflected in the CA Department of Aging's statewide strategic plan

9) Developing state and local plans to improve access to services

10) Recommending the distribution of health and human service funding to service providers, giving priority to applicants that demonstrate adequate arrangements for access to their service, whether by public transportation or other means

3. Improve and Expand Public Transportation Options to Address Transit Needs of Elderly Persons

a. Amend the State Transportation Development Act and related regulations to ensure that all unmet transit needs in rural areas that are reasonable to meet are adequately identified and addressed.

b. Call for each transportation planning agency to develop and annually update a Strategic Mobility Plan for Aging Riders utilizing a variety of transit modes (including, but not be limited to: paratransit, flexibly routed neighborhood-based small bus service, route deviation service, call-a-bus service, user-side taxi subsidies, and other innovative accessible alternatives) to meet the demand for**:**

1) Evening and weekend services
2) Round trip service scheduling
3) Same day service
4) Cross jurisdictional service
5) Adequate rural pick up sites

6) Door to door services under special circumstances

c) Amend housing and social service facility funding application eligibility criteria to include consideration of direct access to transit in the location of all new services, and at the time contracts for services at existing locations are reviewed for renewal.

4. Provide Incentives for Technological Improvements

a. Subject to the availability of resources, develop policy and funding to provide at a minimum:

1) Incentives for the production of clean, safe and accessible public transit and paratransit systems, including the replacement of conventional lift-equipped buses with low floor buses with automatic ramps.

2) Support for increased annual appropriations and authorization levels for federal programs that serve rural and urban elderly and disabled populations. These include Federal Transit Administration (FTA) Section 5310 and Section 5311 programs. Efforts need to be continuous.

3) Support for new federal sources to fund operating and capital costs for innovative accessible alternatives to fixed route and rail transit services.

4) Enforcement of federal regulations that call for coordination among federally supported transportation programs. California Department of Transportation, the Area Agencies on Aging and the FTA should all be involved.

5. Increase Driver and Pedestrian Safety

a. Implement the recommendations of The Task Force on Older Adults and Traffic Safety (OATS) report. The Task Force detailed 53 action items under the following seven main recommendations: [21]

1) Institutionalize a statewide system for the prevention of traffic-related injuries among older adults.

2) Institutionalize effective and equitable driver assessment and licensing practices within the California Department of Motor Vehicles (DMV).

3) Facilitate older adult risk identification and risk reduction practices.

4) Improve the ability of health care and service providers to assess traffic safety risk and minimize the impact of health impairments on safe mobility.

5) Establish roadway infrastructure and land use practices that promote safety.

6) Promote safer motor vehicle designs.

7) Expand the existing research and knowledge base about older adult traffic safety.

[21] California Task Force on Older Adults and Traffic Safety, *Traffic Safety Among Older Adults: Recommendations for California.* San Diego: Center for Injury Prevention, Policy and Practice, San Diego State University, August 2002.

6. Provide Functionality-Specific Training

a. Provide Safe Driver Training - Mature driver education programs and materials should be specifically matched to participants' functional needs.

b. Provide Mobility/ Public Transportation and Travel Training

1) Provide older driver training in areas not currently served by CTSAs.

2) Use "how to use public transportation" training currently provided by CTSAs and public transit operators as a model.

3) Provide training to drivers in how to safely transport older adults and persons with dementia.

7. Provide Transportation Alternatives for Californians of all Ages with a Special Emphasis on Those who Choose Not To or Can No Longer Drive[22]

a. Depression Prevention Programs are needed to help older adults (and their families and caregivers), who experience age-related health and functional decline and decide to stop driving, make the transition between driving and not driving.[23]

b. Provide an affordable and equitable range of transportation alternatives for persons who choose not to drive or have lost their drivers licenses due to not passing a visual, written, or behind-the-wheel driving test.

c. Older adults who are no longer driving should be referred to the Mobility Management Centers to be connected to the appropriate transit service mode, and receive training on how to access such services. In addition, increased operational and capital funding should be made available to these coordinated transit programs to handle the increased demand.

d. Research is needed in pre-cessation planning and educational techniques that would create, identify, and test strategies to help drivers cope before, during, and after driving cessation. Such research should include assessments of whether such programs reduce the likelihood of depression among older drivers going through this process.[24]

8. Support Pedestrian-Oriented Facilities and Services[25]

a. Provide balanced transportation/mobility options to make it possible for residents to have options to walk, bicycle or take transit to shop, work or participate in activities. Such a system would:

1) Foster healthy pedestrian (walking) lifestyles

2) Improve connections between destinations with safe walking routes

3) Provide recreational and fitness opportunities such as elder-friendly trails

4) Improve pedestrian access to transit

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[22] *Transportation for Californians Who No Longer Drive.* Sacramento: Business, Transportation and Housing Agency, April, 2002

[23] Ragland, Satariano, MacLeod. Page 10.

[24] Ragland, Satariano, MacLeod. Page 10-11.

[25] *Leadership Action Strategies*. San Diego: Leadership for Active Living. San Diego State University (SDSU), January 2003. Page 10. A program supported by the Robert Woods Johnson Foundation. Collaborating organizations: ICMA, Local Government Commission, NGA Center for Best Practices, RJW, SDSU.

SERVICE INTEGRATION AND COORDINATION

1. Plan and Implement Integration and Coordination Strategies

a. Subject to the availability of funds conduct a Mobility Summit. The purpose of the summit would be to:

1) Proceed with efforts to implement specific strategies and recommendations emerging from the transportation component of the Statewide Strategic Plan on Aging.

2) Eliminate fragmentation.

3) Promote the establishment of the California Mobility Council and Mobility Management Centers.

4) Establish an ongoing Mobility Task Force with responsibility to monitor implementation and ongoing compliance with policies, standards and expected outcomes. Task Force responsibilities would include:

- Creating local "mobility management centers" with the ability and responsibility to promote and/or provide coordinated services, policies, planning, and funding among human service and transportation agencies.
- These mobility management centers should also serve to identify needs, connect riders with appropriate transit services, provide accessible service information in alternative formats, provide one-on-one and/or group mobility training services, develop and implement a variety of service delivery options and broker inter-jurisdictional trips.

b. Conduct an assessment of the adequacy of available transportation resources to provide access to Medi-Cal services, and make recommendations to address gaps and inadequacies. At a minimum, ideas to explore include:

1) In areas without qualified Medi-Cal non-emergency medical transportation (NEMT) providers, help private companies overcome the barriers to participating in Medi-Cal (e.g. easier completion of transportation authorization requests, faster reimbursement).

2) Contract for NEMT with public agencies, with safeguards to avoid replacing other financial resources. Consider use of brokerages as in Washington and Oregon.

3) Explore ways for local agencies to supplement Medi-Cal NEMT in ways that avoid state fiscal impacts, for example: having the local agency provide the state Medicaid match, recognizing that federal waivers may be needed.

4) Incorporate transportation into waiver programs for home and community-based services.

2. Provide a continuum of coordinated services

a. Consolidated Transportation Service Agencies (CTSA) should take the lead in facilitating coordinated social services transportation, per AB 120 (Statutes of 1979).

b. The California Department of Transportation should work with the CTSAs and other paratransit providers and advocacy groups, in a support role. Focus areas would include:

1) Facilitating coordination of services and regional interconnectivity which would maximize the use of state funds.

2) Continuing training programs provided by Department of Transportation to paratransit, supplemental transportation programs, and small transit operators in areas such as transit technology, research and analysis, vehicle procurement and maintenance, and financial and program management.

3) Creating mechanisms that increase coordination of local transportation services and connect older people with the widest possible range of such services, regardless of the number and types of entities that operate them. Useful mechanisms may include:

- Funding coordination incentives
- Agencies actively working with seniors to identify their needs, connect them with services, help develop those services, and promote coordination among the services ("mobility managers" or "care navigators")
- Funding to public and nonprofit transportation agencies to provide planned transportation services specifically designed and implemented to meet the special needs of elderly individuals and individuals with disabilities

4) Providing assistance to help develop new or expand existing community-based transportation services with access to funding.

5) Using "smart cards" to simplify access to services

6) Using subsidized taxi service for individuals with the greatest need, determined according to prescribed criteria.

7) Developing trip planning services using toll free phone numbers and the Internet

3. Strengthen Consolidated Transportation Service Agencies

a. Subject to available resources increase funding and authority of the CTSAs to implement their mission. Expand their mission to designate them as "Mobility Managers," and the source of travel and mobility training. [26]

4. Take a More Proactive Role in Land Use and Local Housing Planning Processes to Ensure Transit-Oriented Development

a. Ensure that public transit is addressed at the new development planning stage, before buildings are built, in order to:

1) Include adequate space for bus stops, turn-arounds and shelters

2) Address other transit and/or mobility needs appropriate for the new residents.

[26] In this context travel training is defined as education and training to use fixed route services. Mobility training is defined as education and training in the availability and use of paratransit, human service programs, and other supplemental transportation programs.

b. Human service agencies should expand participation in the transportation service planning process to get better transit service for their older clients.

D. The Housing Continuum

BACKGROUND

Independent Housing

Excerpts from a report by Jon Pynoos, Christy Matsuoka and Phoebe Liebig [27]

On the surface, it appears that the housing situation of older persons is a testament to the success of American housing policy. Nationally, close to 80% of householders age 55 or older own their own homes, most having been supported by government-backed financing and tax advantages. Home equity accounts for approximately 44% of the assets of older households and represents a significant financial resource. Housing for older persons is generally in good condition, and few live in overcrowded conditions. They have also been major beneficiaries of direct housing subsidies: an estimated 1.5 million elderly households receive housing assistance in the form of such programs as public housing, Section 202 and 221d3 housing, and Section 8 certificates and vouchers (US Housing and Urban Development (HUD), 1999). With these findings in mind, it is understandable that over two-thirds of persons 50 years and older in a national survey reported that they were "very satisfied" with their housing and their neighborhoods.[28]

These achievements, as impressive as they seem, present an overall picture of older adults that masks the serious housing-related problems of many older Californians.

Continuing Care Retirement Communities (CCRC) provide options for all levels of needs. The CCRC offers a combination of independent housing with nutrition, healthcare, social support and physical security. The drawback is that CCRCs are often expensive. [29]

Minority populations, persons with low incomes, women, and those living alone warrant special attention because of concerns related to housing affordability. A large number of elderly Californians are burdened with high housing costs and in urgent need of affordable housing, which is in limited supply. These older adults live on fixed incomes with limited ability to increase earnings. Shared housing is an alternative for low-income elderly that involves either a group residence with common space or a homeowner who rents out unused rooms. This option, however, does not address the need for health and social services.

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[27] Jon Pynoos, Christy Matsuoka, Phoebe Liebig. *Housing for Older Californians.* Berkeley: California Policy Research Center, University of California, 2001.

[28] Understanding Senior Housing: Into the Next Century – Survey of Consumer Preferences, Concern, and Needs. Washington, DC: AARP, 1996.

[29] Harry R. Moody. *Aging – Concepts and Controversies, 4th Edition*. Thousand Oaks, CA: Sage Publications, Pine Forge Press, 2002. Pages 17-18

Many older adults express a strong desire for continuity in their living arrangements, yet often live in physically unsupportive environments that lack the necessary features to ensure safety and accessibility. Many older adults reside in substandard dwellings in need of repair or rehabilitation, which endanger their safety. Instead of facilitating older persons' ability to grow old safely, independently, and with dignity, many settings have become a source of the problem itself.

Finally, despite their preference to remain in their own homes, many older persons have limited options, which may lead to institutionalized settings. One in four of those 85 and older (primarily women) reside in nursing homes or some other forms of residential care facilities that provide services and environments that offer little privacy, choice, or control over one's life. Older adults should have access to a variety of community-based housing options and supportive services to enable them to age in place and to delay institutionalization.

Residential Care/ Assisted Living

Excerpts from a report by Robert Newcomer and Robert Maynard[30]

Assisted living facilities offer residents and their families a homelike environment with personal care. They are a desirable alternative to a nursing home as they promote independence and privacy, but vary broadly in the services offered, from minimal help with the activities of daily living (ADL) to complete nursing care.

The residential care and nursing home industries are in transition, attempting to adapt to unprecedented changes in health and long term care. Adaptation to these changes has implications across and among the various levels of care, including residential care, home care, nursing homes, primary health care, and hospitals. The most visible changes include practices by states and providers to redefine the levels of frailty that can be maintained in supportive housing settings, and a substantial private sector investment in the construction of assisted living facilities. These changes are occurring in a historical context where relatively little is known about the population served in supportive housing or of the quality of assistance that might be available as frailty levels increase.

Public policy is playing a major role in facilitating the changes affecting the case mix and supply in the residential care/assisted living industries, yet little is known about the industry, the population served, and the effectiveness of the reimbursement and quality assurance systems being developed. The financial chaos recently affecting the private for- profit assisted living industry raises a further concern about the financial stability of publicly traded corporations in this industry. Finally, there are no national and few statewide data systems in place that monitor and evaluate changes in resident case mix or how changes in reimbursement, licensing, staffing, and staff

[30] Robert Newcomer, Robert Maynard. *Residential Care for the Elderly: Supply, Demand, and Quality Assurance*. Berkeley: California Policy Research Center, University of California, 2001.

functions may affect the delivery system and the quality of care provided. These limitations apply nationally as well as specifically in California.[31]

Nursing Homes

Nursing homes are more commonly thought of in terms of long term care, rather than housing. This plan, however, will deal with nursing homes in the context of "shelter," so as to address the continuum of housing that is and will be needed by older adults.

Excerpts from the book by Harry R. Moody, Aging – Concepts and Controversies, 4th Edition: [32]

"The term "nursing home" can refer to several different kinds of facilities or institutions:

- Skilled nursing facility – Offers medical care, as well as everyday personal care services to elderly or disabled people
- Intermediate care facility – Gives health-related care to patients needing a lower level of support.
- Extended care facility – Offers short-term convalescent help to patients coming from hospitals for an extended period of time."[33]

"The growth of today's nursing home population is partly a tribute to medical technology and the success of the longevity revolution. But it may also reflect the fact that American society has failed to provide accessible alternatives to living in a nursing home, namely, long term care based in the home or community. A sizable number of people in nursing homes don't need to be there and could probably live in community settings, if appropriate services were available."[34]

"In nursing homes, the daily regimen is carefully organized and scheduled, so residents may lose any sense of control over their environment and easily become depressed. A lot of criticism of nursing homes finds support in careful observational and journalistic stories that expose poor conditions in some institutions…. It is understandable that so many older people today fear institutionalization."[35]

"On the other hand, it is important to remember that, just like schools or hospitals, the quality of nursing homes varies widely. The stereotyped view that "all nursing homes are bad" is mistaken and does a disservice to elderly people who actually need skilled nursing care, not to mention to the untold numbers of devoted nursing home employees. Government monitoring and regulation have meant that nursing homes today are much better than in the past, and improvements continue." [36]

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[31] Newcomer, Maynard. Residential Care for the Elderly, page 20.
[32] Harry R. Moody. *Aging – Concepts and Controversies, 4th Edition*. Thousand Oaks: Sage Publications, Inc., Pine Forge Press, 2002. Excerpts from pages 20-22.
[33] Moody, page 20.
[34] Moody, page 21
[35] Moody, pages 21-22
[36] Moody, page 22. Moody references work by Kane, Rosalie A. and Kane, Robert L., *Long Term Care: Principles, Programs and Policies*. New York: Springer, 1987.

Moreover, there is a common misconception that, once someone is admitted to a nursing home, residence there is inevitably a live sentence. In fact, 32% of those in nursing homes stay less than a month; many return home.

Among all people over 65, only about 5% (1.6 million people) are in nursing homes at any given time. In other words, it is a mistake to imagine that most or even many older people are in nursing homes. But this low 5% figure may understate the importance of nursing homes in the lives of the very old. It turns out that the percentage of those who will spend *some* time in a nursing home before they die is much larger: up to 40% of people aged 65.

THE VISION - In the year 2020…

Independent Housing

A shift related to the incorporation of transportation in land use and community planning, stimulated a building boom in higher density, affordable housing.

Affordable housing has been substantially increased by replacing numerous underused strip malls on public transportation routes with multi-use, walkable, mini-communities. These communities are a mixture of owner occupied and rental units and are designed to be multi-generational to avoid “ghettoizing.”

In addition to housing, new developments include transportation stops, walking pathways, a variety of small businesses, community and/or health services and feature significant landscaping and seating that encourage social interaction. Small businesses are thriving in this environment, with many owned by or employing seniors that live in the complex.

The building boom was stimulated in part by tax credits for building affordable, accessible housing located near services and shopping. Another stimulant was incorporating transportation planning into the land use and development process, which brought about traffic congestion relief for neighbors and greater mobility for new residents. Universal design and visitabilty features are now built into every home, since their advantages are now obvious to the general population.
The result is a dramatic increase in the affordable housing supply and a positive stimulus to the economy.

Housing in rural areas now incorporate services and transportation in much the same way that early towns/communities were formed in this country. While there are development set-asides for seniors, most communities are truly intergenerational and diverse, with residents of all ages and cultures.

Existing housing has also been improved. Low income older adults no longer need to live in substandard conditions thanks to self-sustaining loan programs that provide eligible individuals with the funds for repairs and needed modifications. In addition, volunteer programs that help older adults with needed home repairs have sprung up

in communities around the state. Besides a safer living environment these programs have fostered lasting intergenerational relationships between volunteers and recipients.

To ensure that increased supply benefits renters as well as home owners, intense lobbying efforts convinced the Federal Housing and Urban Development to significantly expand rental assistance programs.

Community Supportive Services

For older adults and persons with disabilities who wish to stay in their homes, there is a broad and plentiful array of community support services, for both in the home and outside the home.

The substantial increase in community capacity could not have been accomplished without redesigning long term care assessment process and analyses of the collected assessment data. This data provided the means to determine service needs in every county. With this information finally in hand, community based organizations were able to assess the adequacy of and ultimately provide the array and quantity of community services necessary to help older adults stay at home if they chose to do so.

Assisted Living, Residential Care

Assisted living has long been integrated into the Medi-Cal program. This has enabled individuals with greater needs to live more independently and with more freedom. Due to data captured since California's assisted living waiver demonstration project began, the state and local governments now have good market data and are able to accurately project the demand for licensed assisted living facilities. By tracking client outcomes, this data has also made it possible to continuously improve quality of care.

Nursing Facilities

California has traditionally had a low ratio of nursing home occupancy compared to all other alternatives, and this percentage has continued to moderately decline. While much focus has been on encouraging community-based services, nursing facilities continue to provide care for individuals with continuous or unstable health conditions. Nursing facilities have changed dramatically. They are substantially more home-like and nurturing, yet still provide nursing assistance and supervision to individuals who need that level of care. These facilities no longer look like hospital floors. Schedules are built around the resident's preferences and needs and all residents are encouraged to be as independent and involved as possible in activities within and outside the facility. Multi-use rooms and areas of the grounds are routinely used by outside community groups, integrating the community into the facility. Many nursing homes, especially in rural areas, provide community day services plus emergency and scheduled respite for family caregivers.

These changes coupled with appropriate reimbursement strategies and more effective regulatory oversight, have substantially improved the quality of life and care for nursing facility residents.

HOUSING RECOMMENDATIONS

INCREASE AFFORDABLE HOUSING SUPPLY

1. Target Low-Income Housing Tax Credits

a. Include older low-income adults in the priorities for the allocation of low-income housing tax credits. A tax credit program should include more supportive housing, housing linked to services, and assisted living. (For example, Massachusetts has used a large proportion of their tax credits for the elderly; Oregon has used them to develop assisted living.)

2. Create Direct Financing Programs

a. Explore the creation of a state housing trust fund as an ongoing and dedicated source of funding for affordable housing that includes earmarked funds to help finance a range of supportive housing options for the elderly.

3. Ensure a Fair Share of Senior Housing

a. Explore potential for funding senior housing through the Housing and Emergency Shelter Trust Fund Act of 2002.

b. Add “frail elderly,” “at-risk elderly,” and/or “very low income” elderly under the Special Needs definition in the California Department of Housing and Community Development’s (HCD) Multi-family Housing Program to insure that the needs of the vulnerable elderly are met.

4. Rental Assistance

a. Maintain current proportion of Section 8 vouchers going to seniors.

1) To increase supply encourage more project-based Section 8 funding to property owners rather than increasing vouchers to individuals.

b. Advocate to require the federal Housing and Urban Development (HUD) department to commit to a major expansion of federal rental assistance so that each eligible household or person can get aid. Rent should be capped at 30% of personal income.

5. Encourage the Development of Partnerships

a. In the competitive ranking of applications for senior housing dollars, California Housing Finance Agency and California Department of Housing and Community Development (HCD) should encourage the development of partnerships with organizations such as Health Maintenance Organizations (HMOs), community-based care systems, organizations representing persons with disabilities, public health, transit providers and second career employment programs.

HOUSING IN ADEQUATE CONDITION

1. Identify Funding Sources and Resources

a. Make funding for home improvements a priority in the state's Consolidated Housing Plan.

1) Expand the use of federal funding sources for home improvements, including the Community Development Block Grant Program and the Home Investment Partnership Program (also known as the HOME program).

2) Consider a state low-interest loan program for home repair for low-income residents.

3) Work with the private and non-profit sector on initiatives that support home repair, e.g., "adopt a neighborhood" or similar program.

4) Enforce codes to keep rental housing in good condition.

ACCESSIBLE HOUSING

1. Encourage Visitability and Universal Design

a. Provide incentives for local governments to adopt mandatory universal design guidelines and ordinances.

b. Provide incentives for builders and developers to adopt visitability design in housing funded by the state.

2. Strengthen Support of Home Modification in Community-Based Programs

a. Include comprehensive home assessments in home and community-based services programs (e.g., Multipurpose Senior Services Program (MSSP) and other care management services) to help older persons to age in place for as long as possible.

b. Community service providers should be trained in Fair Housing Laws to improve their ability to advocate with landlords for improvements in housing settings.

c. Review local government housing elements, including programs, services, and funds for accessibility to ensure that they include adequate sites for all housing needs, including households with special needs.

d. Provide local housing entities with information on the Olmstead decisions and emphasize the importance of making housing available to meet Olmstead goals.

e. Require that Consolidated Plans and Housing Elements reflect Olmstead goals as a condition of certification.

f. Establish Senior/Olmstead Ombudsman and grievance procedures to process reports of non-compliance.

APPROPRIATE HOUSING & SERVICES

1. Utilize New Integrative Models of Elderly Housing

a. Increase flexibility in the use of funds at the state and local levels to allow the creation of housing development models that incorporate transportation,

community spaces, walking paths and provide services to the adjacent neighborhood.

b. Increase flexibility in the use of funds at the state and local levels to allow the adoption of multi-use models of housing that incorporate:

1) Public (e.g., senior centers, day care centers, classrooms)
2) Commercial spaces (e.g., restaurants, stores)
3) Safe walking routes within neighborhoods/subdivisions
4) Safe routes to transit stations and stops
5) Park and recreation facilities and services

c. Provide incentives or priorities for California Housing Finance Agency (CalHFA) senior housing financing applications that demonstrate innovation by providing housing linked with services by encouraging partnership between developers, transportation providers, service providers and other community organizations.

d. Develop closer working relations among HCD, California Department of Transportation, California Department of Aging (CDA) and the California Health and Human Services Agency (CHHSA) in order to foster innovative and practical housing developments, including intergenerational living arrangements.

e. Encourage area plans developed by the Area Agencies on Aging to incorporate and advocate intergenerational living opportunities, integrated housing and active living models.

INTEGRATE COMMUNITY PLANNING WITH SENIOR AND LONG TERM CARE PLANNING

1. State Enforcement of the Housing Element in Local General Plans

a. Strengthen state housing element provisions and enforcement to insure that all local governments plan and produce housing for all people in the community**:**

1) Actually use “in lieu fees” for affordable housing projects and modifications.
2) Submit housing plans with elements that address the local need for senior housing.
3) Submit housing plans that address mobility and transportation needs.

2. Ensure Housing Planning is Consistent with Olmstead Plan

a. HCD and the other Long term Care Council (LTCC) participating departments should evaluate planning policies and practices to ensure that planning for housing is consistent with California’s Olmstead Plan (see Appendix H).

3. Incentives for Smart Growth Projects[37]

a. Develop policy to ensure that, in competitive funding processes in which state money for housing is distributed, the state offers preferential treatment to those

[37] Smart Growth Principles include converting obsolete or unsightly strip malls that are already transportation corridors, creating "walkable," mixed-use communities, and minimizing isolation from transit, healthcare.

applicants who incorporate Smart Growth principles. (Examples include HCD, the Housing Financing Agency, and the State Treasurer.)

b. Encourage compact multi-generational, mixed-use neighborhoods that make it easy for residents to walk or bicycle to stores, parks, and social destinations.[38]

c. Apply Smart Growth, mixed use, intergenerational, active living, transit-friendly principles to the improvement of existing neighborhoods, as well as new projects.

4. Increased Emphasis on Transportation Needs in Community Design Criteria

a. Going forward, access to housing by public transportation should be a criteria for project location and /or funding. The costs of client transportation to the client, the service organization and affected agencies must be considered.

5. Strengthen Advocacy Efforts

a. Consumers and community-oriented advocacy organizations need to take more responsibility for getting involved in urban and regional planning for the purpose of:

1) Educating decision makers regarding senior housing needs
2) Educating the general public regarding senior housing needs
3) Educating independent living advocates to train senior advocates and bring them into the advocacy network
4) Educating seniors on how to be their own best advocates

6. Counties should consider adopting inclusionary zoning ordinances which require mixed-income housing.

COLLECT BETTER HOUSING DATA

1. General Data Needs

a. Data should be collected and analyzed on the housing needs of the elderly in California, including the need for supportive housing and assisted living, the prevalence and need for affordable housing among the elderly, and updated information on the characteristics of senior housing facilities and residents.

2. Supply Related Data

a. Subject to the availability of resources, develop a database of housing resources available to seniors and persons with disabilities in each city and county. Information should be collected on the number of Section 8 housing vouchers available.

b. Subject to the availability of resources, track the number of subsidized public housing units, including the number of those units that are occupied by people

[38] Leadership Action Strategies. Page 15.

without disabilities, number of bedrooms and bathrooms in each unit, and any other data deemed relevant for planning purposes.

c. Local governments should identify supply and location of housing units that are accessible and/or convertible.

d. Make this information available to the public in a database where individuals can learn about the availability of accessible and affordable housing in their communities.

ASSISTED LIVING/RESIDENTIAL CARE AND NURSING HOME RECOMMENDATIONS

1. Revise the Assessment Process

a. Individual assessments must be completed prior to admission to any type of residential facility to determine supports and services needed for individuals to make an informed choice as to the most appropriate and integrated setting.

b. The individual assessment/planning process should be "person-centered" and focus on the person's goals, desires, cultural and language preferences, abilities and strengths as well as relevant health/wellness/ functional levels and skill development/training needs.

2. Improve Affordability of Assisted Living Facilities (ALF)

a. Explore governmental funding sources, such as Supplemental Security Income, HUD Section 8 vouchers, and the Medicaid waiver program to pay for housing and services in assisted living facilities (licensed as Residential Care for the Elderly).

3. Make Assisted Living a Medi-Cal Program

a. Implement a scientifically valid AB 499 Assisted Living Waiver Project.[39]

b. Explore the possibility of applying to the Federal Government for a permanent waiver for assisted living.

4. Evaluate Barriers to Private Third-Party and Medi-Cal Reimbursement for Residential Care Facilities for the Elderly (RCFE)

5. Ensure the Quality of All Assisted Living/Residential and Nursing Facilities

a. Subject to the availability of resources, increase funding, quality and frequency of the *survey and certification* of nursing homes.

1) Ensure that the focus is on quality outcomes of patients in the survey. Focus on patient outcome measurements as the basis for the survey.

2) Provide adequate funding/staff to enforce the standards of care that are required by the Federal nursing home reform law.

3) Fund unannounced, annual, comprehensive inspections

[39] Newcomer, Maynard. *Residential Care for the Elderly*, page 20.

b. Address workforce issues so these facilities will attract qualified persons who are well trained and adequately compensated

c. Require geriatric and dementia training/education for all owners/managers

d. Establish uniform standards for admission agreements that ensure language is clear and readable, not using legal terminology, and provides full disclosure of services and fees.

e. Subject to the availability of resources, fund the state's ability to ensure quality:

1) Fund the state's ability to respond to complaints in a timely manner

2) Provide adequate funding for the ombudsman program and increase the public's awareness of this resource

3) Ensure quality of care through adequate reimbursement rates

6. Make nursing homes/institutional structures more home-like and supportive of independent living

a. Create incentives in the form of lower interest loans or loan preferences to assist nursing facilities that adopt principles and undertake architectural changes to make the institutional structure look and feel home-like and supportive of independent living. Examples include the Eden Alternative and the Nursing Home Pioneer Network.

E. Staying Well

BACKGROUND

Optimizing Wellness

Excerpts from a report by Teresa Seman[40]

In recent decades, there has been a growing appreciation for the fact that older age, while a time of greater risk for declines in health and functioning, need not inevitably be associated with such negative outcomes. Indeed, there has been an increased awareness that considerable numbers of older adults continue to enjoy relatively high levels of physical and cognitive functioning and remain actively engaged in various life pursuits well into their later 70s, 80s, and even 90s. One primary reality that needs to be highlighted is, that despite the considerable and needed attention that is devoted to the health and functional problems most commonly seen in older age groups, aging is not uniformly associated with significant disease and disability.

A more positive trajectory of aging is possible, one that is characterized by avoidance of many, if not all, of the common age-related diseases and, more importantly, by the maintenance of relatively high levels of physical and cognitive functioning as well as a continued engagement in life pursuits.

The importance of such a view of aging lies not only in the fact that it offers the possibility of more positive outcomes for individuals as they grow older but, equally importantly, it serves to remind us that our older population need not, and should not, be seen as only (or even largely) a drain on society's resources, particularly our health care resources. Rather, our population of older adults can also be seen as an important resource for our society, one that includes large numbers of individuals whose health and functioning are not significantly impaired and who have a wealth of knowledge and skills to offer.

Like the evidence regarding health risks for the population at large, the factors that contribute to disease and disability in older adults include a number of potentially modifiable characteristics—i.e., lifestyle or behavioral factors (and health conditions related to these behaviors) that suggest the possibility for interventions to reduce risks for disease and disability among older adults.

The concept that society should invest more in efforts to promote more successful aging is supported by a growing body of evidence. This evidence clearly indicates the potential for successful intervention, even when such interventions only begin at older ages. This is not to negate the benefits of encouraging more healthy lifestyles across the life course. However, the evidence also indicates that interventions to promote more successful aging can be effective even when individuals make these changes in later life.

[40] Teresa Seman. Optimizing Trajectories of Aging in the 21st Century: Can We Promote More Successful Aging for Coming Generations? Berkeley: California Policy Research Center, University of California, 2001

Areas for Potential Intervention to Promote Successful Aging

Behavioral Focus
- Promote regular physical activity in daily life (e.g., walk up stairs versus elevator; walk rather than drive short distances)
- Promote and facilitate participation in regular physical exercise programs

Social Focus
- Promote continued social engagement with family and others, including facilitating participation in social activities of various sorts for older adults (e.g., through community groups)
- Promote development of social roles for older adults that enable them to continue to make contributions to society after retirement

Psychological Focus
- Promote sense of self-efficacy
- Promote sense of continued social contribution

There are a number of existing California programs that can serve to promote continued social engagement for older Californians. For example, the California Department of Aging currently administers a number of programs that promote volunteer and paid employment opportunities for older Californians. Adult education opportunities are also growing in California and can provide opportunities for older adults to maintain and even enhance their cognitive, educational skills. Classes may also provide older adults with skills to improve their employment opportunities.

State Programs That Impact Successful Aging

California Department of Aging
- *Foster Grandparent Program* - Senior volunteers work with children who have exceptional needs
- *Brown Bag Program* - Senior volunteers collect and distribute surplus food to income- eligible seniors
- *Senior Community Services Employment Program* - Provides part-time subsidized employment for income-eligible persons over age 55
- *Senior Companion Program.* Senior volunteers provide peer support to frail older persons in their local communities
- *Transportation* - Local agencies secure escorts and travel vouchers or provide vehicles to assist in transporting older persons to essential services

Department of Motor Vehicles

- Mature Driver Improvement Kit
- Mature Driver Improvement Course
- Information on alternative transportation services in communities
- Issues handicap license plates to assist mobility needs of the elderly

Employment Development Department

- *Senior Worker Advocate Office* - Established January 1, 2000 to promote public awareness concerning the employment of senior workers. Major activities:
- *Information and referral* - Provides information and referral services to employers, senior workers, and public and private agencies that are dedicated to senior worker employment and training
- *California Mentoring Works* - Assists in developing and implementing senior mentoring programs in local areas throughout California
- *Senior Worker Outreach* - Promotes public awareness regarding the employment of senior workers

PREVENTIVE HEALTH CARE [41]

The overall goal of preventive health for seniors is avoiding or slowing the rate of disease progression and reducing the risks of disability and death. Access to preventive resources and health services affect differences in health and vitality. These services are particularly important because preventive actions to improve health are unknown to most people.

Education and counseling related to primary prevention are changing health behaviors and improving health status. Older people in general may be more motivated than members of other age groups to adopt health behavior changes because of their firsthand experience, as well as the experience of their peers, in coping with chronic diseases. Therefore, they are an excellent target population for preventive health programs.

Within older age groups, relatively high users of health care services tend to be more amenable to participation in health promotion programs. The success of a health promotion program for an older person is related not so much to the information conveyed about activities that promote health, but rather how that information is communicated and how specific actions are targeted. To improve adherence to health plans research suggests that time should be spent with older

[41] Excerpts from the California Commission on Aging's *Statement of Findings, Senior Related Health Issues.* . Sacramento: Planning for an Aging California - An Invitational Forum, April 1-2, 2003.

clients determining how to effect a desired change and a plan for change should be broken down into easily managed components. Creation of simple short-term goals and targeting of behaviors has also been found to facilitate change[42].

The Preventive Health Care for the Aging Program (PHCA) was established in 1973 to provide preventive health care to California's older population. The mission is to enhance and protect the health of Californians, 55 years and older. Program goals include the promotion of healthy life styles, increasing access to health services, and improving quality of life. PHCA also assists seniors in managing chronic health conditions, including arthritis, cardiovascular diseases, and diabetes, and provides counseling and instruction in disease prevention activities. The program serves about 50,000 seniors a year, and targets seniors who are low-income, ethnic minority, or have limited access to health care.

Data from the program demonstrates that it is effective in detecting serious chronic diseases such as hypertension and diabetes. Evaluation research has demonstrated the program's effectiveness in both raising levels of preventive practices and in improving health-promotion behavior in this older population[43]
At a time when our senior population is growing, efforts to promote health and functional independence among this group is of major importance and essential to controlling the costs associated with chronic diseases and frailty including Medi-Cal's long term care expenditures.

Clearly PHCA closes the gaps in health care for seniors who have a provider but do not receive thorough health screenings or preventive education--the 65% who receive new diagnoses is a testament to PHCA's great value and need.

THE VISION - In the year 2020…

Healthy Aging

As in their youth, California seniors are still independent and taking responsibility for their own health. A greater number of older adults are living in walkable, multigenerational communities and are fully engaged in community life, which has increased physical and social activity. This, plus taking advantage of screening programs, has led to a substantial decrease in disability rates among older Californians.

Older adults attend healthy lifestyle and health education programs through the Community Colleges, Adult Education, the CSUS and UC systems and through classes offered in Community Centers and by community based organizations. As a result they are making more appropriate lifestyle choices and eat more appropriate foods than any older generation before.

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[42] Patrick Fox, PhD, Wendy Breuer, RN, MHP, and Janice Wright, RN, MS, *Effects of a Health Promotion Program on Sustaining Health Behaviors in Older Adults*. American Journal of Preventive Medicine, 1997, 13 (4).
[43] Preventive Health Care for the Aging (PHCA) Program FY 2000-01 Reports. Sacramento: California Department of Health Services, Preventive Health Care for the Aging Division.

Non-profit and community-based organizations are creating and widely distributing health promotion information in various accessible formats and multiple languages to their members and constituents. Outreach efforts have ensured that information is reaching diverse cultures.

Because of the great responsibility Californians have taken for their own health in the early years of the century, they are thriving and living more independently than any previous generation.

Prevention

Years ago California made a commitment to public health and prevention. The state is now reaping the economic benefits of a healthy population. In fact, prevention programs have become the centerpiece of the health care delivery system. In addition to very strong public health screening programs, supporting organizations routinely sponsor health-screening days so that, regardless of income, any individual can receive an evaluation of their risk potential for the most common age associated conditions. Evaluation counseling makes it possible for many seniors to better self-manage their own health conditions, including arthritis, diabetes, and cardiovascular conditions to name a few.

Community Colleges, community groups and private businesses sponsor a broad range of prevention training opportunities from diet, exercise and tobacco reduction, to oral health and injury and fall prevention.

Education, Life-Long Learning

The California Department of Education and Community College adult education curricula are well publicized and classes are well attended. They cover a broad array of personal growth topics, including:

- Retirement preparation
- Social, travel, and recreational opportunities
- Job training and retraining

Classes have been augmented with career and retirement counseling. Retirement preparation courses are attended by younger adults who are already making changes early enough to have a positive impact on their retirement years.

Civic Engagement/Volunteerism

Community based organizations have launched vigorous volunteer recruitment programs in order to attract seniors to community service.

- Younger retirees are volunteering in record numbers
- Retired Senior Volunteer Program (RSVP) and other unpaid volunteers are filling service and support positions of many community based organizations enabling them to serve broader constituencies for less cost

- Organizations like "Seniors Helping Seniors" have hundreds of thousands of seniors across the state working with community programs to provide services to disabled and ailing seniors.

STAYING WELL RECOMMENDATIONS

HEALTHY AGING

1. Promote the Development and/or Expansion of Innovative Community-Based Programs that Support Healthy Aging

a. Subject to the availability of resources, expand or establish programs that provide technical and consultative assistance to local government and non-profit organizations in order to increase access and availability of lifestyle behavior programs.

b. Programs should facilitate participation of older adults in activities such as improved nutrition and increased levels of physical, recreational and social activity.

c. Expand community based programs that encourage physical activity. Examples include, The *California Active Aging Project* [44] that promotes social and physical environments that support healthy aging and 30 minutes or more of moderate activity on five or more days per week, and *America On The Move,* [45] a program that advocates and supports walking an extra 2,000 steps a day.

d. Develop and offer classes in cognitive stimulation that emphasize active participation and structured exercises.

1) Classes should be customized for all levels of cognitive functioning: independent, mild to moderate cognitive limitation and severe cognitive limitation.

2) Classes should be offered in locations as appropriate to the participants, from community colleges and or community centers to nursing homes.

e. Improve access to routine physical and behavioral health care with the use of mobile health clinics and temporary health clinics at locations where people congregate, such as senior centers or faith-based facilities.

1) Establish transportation programs that take seniors to classes and programs.

2. Expand Access to Information on How to Stay Healthy

a. Subject to the availability of resources, expand knowledge of and access to information on how to stay healthy, that is user-friendly, reliable, up-to-date and accurate. Disseminate this information on the Internet, through community based senior centers, faith-based organizations and businesses frequented by seniors.

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[44] The California Active Aging Project (CAAP) is a program within the Physical Activity and Health Initiative (PHAI), a partnership of the California Department of Health Services and the University of California, San Francisco, Institute for Health and Aging.

[45] "On the Move" is an example of a promising national program to encourage physical activity. This program recognizes the importance of changes in the physical environment that can enhance the opportunity for people to be physically active. http://www.americaonthemove.org/

3. Develop a Dynamic Public Awareness Campaign

a. Subject to the availability or resources, develop a campaign that will increase the public's awareness of aging and the activities that support aging successfully, including:

1) The benefits of nutrition, physical activity and social engagement and promotion of cognitive vitality/mental fitness.

2) The importance of having a durable power of attorney for health care.

CIVIC ENGAGEMENT

1. Volunteerism

a. Promote Civic Engagement to Serve and Offer Opportunities for Service to Older Adults

1) Work with the Governor's Office on Service and Volunteerism – GOSERV

- Expand opportunities for engaging seniors and set standards for effective training and supervision of volunteers.[46]

2) Establish a Service and Volunteerism Committee under the California Commission on Aging.

- Activities of this committee might include encouraging non-profit and community-based organizations to sponsor Civic Engagement Fairs (regional, county, and/ or city) to promote civic engagement throughout life.

3) Work with county Superintendents of Schools, Adult Education and higher education to promote volunteerism.

4) Get business support to encourage workers to volunteer with aging adult programs. Develop employee programs that provide incentives for volunteers.

- Allow workers to take time off to volunteer. For example, companies could sponsor volunteerism days once a year.

2. Broadly Implement Life Long Learning Best Practices

a. Maintain and enhance model programs that provide no or low cost educational enrichment programs to seniors.

3. Continue to Support Parks and Recreation Programs

a. When updating the State Parks Master Plan incorporate considerations of the elderly, both as users and volunteers.

b. Local government is encouraged to maintain funding for recreation programs and community centers supporting the senior community.

c. Recognize and encourage continued support for focal point senior centers that are promoting healthy aging and exemplary programs for seniors of all ages.

[46] Called for in SB 953 (2002, Vasconcellos).

PREVENTIVE HEALTH CARE

1. Fund the Preventive Health Care for the Aging Program

a. Subject to the availability of resources, consider expanding the Preventive Health Care for the Aging (PHCA) program to all counties as an investment that avoids even more costly acute, primary care and long term care expenditures.

2. Fund Screening Programs

a. Support culturally appropriate older adult health screening programs throughout the State

b. Subject to the availability of resources, set eligibility for screening programs to include persons age 55 and over who may no longer have health insurance through an employer or who never had health insurance and are not yet eligible for Medicare.

c. Screening programs must include:

Hypertension	Immunizations
Dental/Oral	Prostate
Hearing	Mammogram
Vision	Pelvic
Osteoporosis	Health Behaviors
Colo-rectal	Physical Activity
Diabetes	Cognitive function
Obesity	Mental Health
Medical History	

d. Implement a community-based vision-screening program to detect diabetic retinopathy, macular degeneration and glaucoma.

e. Encourage primary care doctors to perform an annual first level Alzheimer/dementia assessment for their patients over 65 years of age.

1) Identify early markers of Alzheimer's so diagnosis can be made prior to manifestation of symptoms.

3. Teach Prevention

a. Encourage health care providers to teach techniques to prevent or reduce chronic functional problems and disabilities.

b. Building upon the current infrastructure, increase education of primary care providers and other health professionals to enable them to evaluate and respond to:

1) Risk factors and/or early signs of diseases associated with aging
2) An individual's risk for fall injury and the causes of falls[47]

c. Expand courses in fall prevention for consumers. Address fall risk factors including, but not limited to: muscle weakness, hypotension, and medication side effects. Stress home assessment to remove physicals risk factors.

d. Expand courses on nutrition and simple preparation of healthy meals.

[47] A joint project of the American Geriatrics Society, the British Geriatrics Society and the American Academy of Orthopedic Surgeons, 2001. *Guidelines for the Prevention of Falls in Older Persons.* Special Series: Clinical Practice, Journal of the American Geriatrics Society. 2001, 49:664-672.

4. Encourage Physical Activity

a. Continue funding public health and community based programs that encourage physical activity. [48]

b. Facilitate participation of older adults in activities such as improved nutrition and increased levels of physical, recreational and social activity.

1) Local governments should address the importance of physical activity by championing community design that incorporates walking, bicycling and active lifestyles.[49]

5. Discourage Tobacco Use [50]

a. Continue funding public health programs, such as the California Tobacco Control Program, that discourage tobacco consumption through targeted approaches to subgroups of older Californians with continued high rates of smoking.

6. Alcohol and Chemical Dependency

a. Develop funding for alcohol and chemical dependency education and awareness campaigns targeted to seniors. Include screening and referral. (Also see alcohol and chemical dependency recommendations in the *Health and Long Term Care* element of this plan.)

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[48] Again, "America On the Move" is an example. http://www.americaonthemove.org/

[49] Leadership Action Strategies. Page 11.

[50] Although tobacco use declines with age, older people are at elevated risk for the ill effects of environmental tobacco smoke. In addition to the link with heart disease and cancer, smoking is a risk factor for the development of osteoporosis as people age.

F. Health and Long Term Care

1. HEALTH CARE

BACKGROUND

Excerpts from a report by William Satariano and Valentine Villa [51]

There are two views about the future health and vitality of the aging population. One view is that increased life expectancy will result in a larger older population with a greater prevalence of illness and disability. In this view, treatments for a number of medical conditions have improved the chances that people will survive, but have not improved the chances that they will survive well. The result is that people survive for a larger period of time with functional limitations and disabilities. Moreover, they are alive and susceptible to develop subsequent health conditions. In fact, these subsequent conditions may be less lethal, but more disabling, e.g., arthritis and osteoporosis.

An alternative view is that future generations of older people may be healthier and more physically fit than older generations of the past. In this view, it may be possible to postpone the onset of chronic diseases to later life, resulting in fewer chronic conditions and less disability for older people.

Although there have been significant declines in deaths due to coronary heart disease and stroke, these conditions are still associated with significant limitations and disabilities, especially for those diagnosed with the disease at older ages. Cancer mortality rates have remained relatively constant. People aged 65 and older are more likely than younger people to be diagnosed with advanced cancer, in particular, the leading forms of cancer (i.e., cancers of the female breast, colon and rectum, and prostate). Diagnosis at an advanced stage elevates the risk of disability and death.

Older people also are more likely than younger people to have prevalent conditions that are not necessarily lethal, such as arthritis, osteoporosis, and cataracts, but are associated with functional limitations and disabilities.

Individuals age 61 or older have an increasing risk for the development of cataracts, glaucoma and macular degeneration and other sight threatening or visually disabling eye conditions as well as systemic health conditions. Most at risk for vision loss include individuals diagnosed with diabetes or hypertension, those with a family history of glaucoma or cataracts, and persons taking systemic medications with ocular side effects.

[51] William Satariano and Valentine Villa. *The Health Status of Older Californians*. Berkeley: California Policy Research Center, University of California, 2001.

Race and ethnicity are associated with health status among older Californians. In general, African-American and Hispanic residents are more likely to be diagnosed with specific chronic conditions, such as cancer. Moreover, they are more likely to be diagnosed earlier in life at a more advanced stage, and therefore are more likely to experience an elevated risk of disability and death.

Place of residence is associated with the stage of the cancer at diagnosis among African-American and Hispanic residents. Residents of some counties are more likely to be diagnosed with more advanced disease than residents of other counties.

Presently, racial and ethnic differences in the number and types of chronic conditions, injuries, and disabilities are generally most pronounced in the middle years (ages 40 to 64). African-American and Hispanic populations, in most cases males, have poorer health and function than the non-Hispanic white population. The future health and vitality of California's senior population depends, in large part, on the fate of this segment of the population as it ages. Those who survive to their senior years may have greater prevalence of chronic disabling conditions. For example, with an increase in the Latino population, it may mean an increase in the prevalence of diabetes and diabetic-related conditions. In addition, if cardiovascular-related mortality continues to decline, it may result in an increase in cancer-related mortality. Moreover, a continuation of current racial, ethnic, age patterns of health would result in an increase in the prevalence of older people diagnosed with later-stage disease, thus elevating the risk for disability and death.

"Evidence is emerging … that societal-level phenomena are critical determinants of health…. Stress, insufficient financial and social supports, poor diet, environmental exposures, community factors and characteristics, and many other health risks may be addressed by one-to-one intervention efforts, but such interventions do little to alter the broader social and economic forces that influence these risks."[52]
"Identifying the most promising strategies for reducing health disparities requires analyzing the pathways from…. root conditions of poverty and discrimination to behavioral and environmental factors influenced by these root conditions…. Ensuring access to health care is essential for reducing mortality and disability and improving quality of life…. at the same time, improving healthcare is not sufficient to alter patterns of health disparities."[53]

"Low income people of color are disproportionately exposed to hazardous conditions in their homes, workplaces and communities. Further, many of their poor health decisions must be seen not only as a cause of poor health, but also as an indicator of an environment encouraging poor health…. There is now a research basis that

[52] Institute of Medicine. A social environmental approach to health and health interventions. In: Smedley BD, Syme SL, eds. *Promoting Health: Intervention Strategies from Social and Behavioral Research*. Washington, DC: National Academy Press; 2000:3.
[53] Rachel Davis, MSW and Larry Cohen, MSW. Strengthening Communities: A Prevention Framework for Eliminating Health Disparities. Oakland, California: Prevention Institute. Prepared for The California Endowment, July 25, 2003. Excerpts from pages 3-4.

supports approaches that alter the conditions in which people live and work. In conjunction with medical approaches that treat the already sick, a preventive strategy to reduce the number of those getting sick in the first place, is critical."[54]

It is essential that the health care system be culturally competent and patient-centered, focusing on differences between individuals and not between cultures or groups of people. To strengthen cultural competence diversity must be maximized in the workforce. Staff must have continuing education and training in culturally and linguistically appropriate service delivery.

Standards for Culturally and Linguistically Appropriate Services

1. Adopt the National Standards for Culturally and Linguistically Appropriate Services (CLAS): [55]
   a. Conducting initial and ongoing organizational self-assessments.
   b. Ensuring that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and are continually updated.
   c. Maintaining a demographic, cultural and epidemiological profile of the community served.
   d. Making conflict and grievance resolution processes culturally and linguistically sensitive.
   e. Making information about the progress of CLAS available to the public.
2. Require providers to offer language assistance in health care and other service settings.[56]
3. Develop health information for patients in their preferred language but also at the appropriate literacy level.[57]
4. Educate patients on how to navigate the health care system and take an active role in their health care.[58]
5. Have physicians collaborate with traditional healers in coming up with the best treatment for patients.

In conclusion, the health and functional status of future (and current) older Californians reflects the current and future racial, ethnic, and regional diversity of the state. Addressing the current and future needs of this growing population will require a coordinated statewide program of surveillance, research, prevention, and treatment.

[54] Davis and Cohen. Excepts from pages 30-31.
[55] American Institutes for Research. Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies and Practices. Office of Minority Health. March 2002. Page 6.
[56] American Institutes for Research. Page 17.
[57] Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo. *Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches.* New York: The Commonwealth Fund. October 2002. Page ix.
[58] Betancourt, Green, Carrillo. Page x.

THE VISION - In the year 2020…

Access to health care is very good and getting better. Californians have enjoyed more than ten years of comprehensive health care that includes dental, vision, hearing, and prescription drug coverage. California led the way in making this a reality throughout the nation. A number of benefits have resulted from this once-controversial concept, including:

- Quality health care for all seniors has eliminated the inappropriate dependency on emergency room care.
- Access to needed health care for children and adults under age 65 has contributed to a new cohort of more healthy older adults because they received needed health treatment and earlier detection of treatable conditions throughout their life.
- The fear of greater cost to business has been completely overcome by the more than 50% reduction in sick days and resultant productivity increase.
- The investment in prevention programs, including health and assessments to the home for needed modifications, has greatly reduced the overall incidence of illness and injury and associated costs.
- Vaccinations and treatment of infectious disease has been timely and appropriate. A financial "health dividend" has resulted from the reduction in communicable disease.
- Inclusion of the population in health coverage has substantially reduced the cost per person ratio and adverse risk to the participating health plans.

BASIC HEALTH CARE RECOMMENDATIONS

ACCESS

1. Substantially Increase Access to Health Care - Support Universal Health Coverage Discussions

a. Support universal health coverage discussions to define what constitutes basic acceptable coverage. Coverage must be affordable and offer a sliding scale based on income.

b. Explore adding a chronic care management reimbursement to health insurance, so that healthcare providers will have an incentive to provide chronic care management.

c Maintain Current Levels of Health Care Insurance

1) Subject to the availability of resources, seek to maintain current levels of health care insurance while seeking to extend coverage to the uninsured.

2) Increase available preventative services and chronic disease self-management programs including current coverage by health insurance carriers.

d. Expand Access to Preventative and Primary Health Care in Rural Areas, including access to specialty providers.

1) Expand ways to deliver quality health care throughout rural California, including increased use of telemedicine, physician assistants, nurse

practitioners, mid-level practitioners, public health nurses and physical therapists.

e. Expand Access to Information - Inform seniors how to get access to health care if they don't have health care insurance

2. Encourage Collaboration Between the Disabled and Senior Communities

a. Organizations advocating for older adults and persons with disabilities should work more closely together and engage in dialogue to foster mutual respect and an understanding of both perspectives.[59] This collaboration should span the entire health care continuum from basic health care, to mental health care to long term care.

3. Ensure Transportation Access to Health Care Facilities

a. Access to health and long term care facilities by public transportation should be a criteria for program and/or facility siting, location and funding. The costs of client transportation to the client, the service organization and affected agencies must be considered in the location analysis.

CULTURAL AND ETHNIC DISPARITIES

1. Develop new approaches to enhance access to health and social services and move subpopulations into the mainstream

a. Increase access to health and human services, train health and social service professionals and paraprofessionals to be multi-lingual.

b. Develop training for health and social service professionals and paraprofessionals that explains the nuances, traditions, spiritual and cultural context and how these link to health and social services. Consider the cultural context for information provided.

c. Ensure a large enough health and social services workforce, invest in youth, e.g., tutoring, math/science/literacy programs and other educational supports.

d. Maintain support for the Healthcare Pathways Continuum Coordinating Council (HPCCC), facilitated by the Office of Statewide Health Planning and Development (OSHPD). The council is committed to increasing access to healthcare in medically underserved areas through development of a culturally diverse and competent workforce and ongoing analysis of California's healthcare infrastructure.

[59] An example of cooperation between the disabled and senior communities is the **Annual Coordinated Leadership Conference** for seniors and adults with disabilities advocating for change, a public-private coalition of California associations and government agencies. Sacramento: California Association of Area Agencies on Aging.

2. Reduce risks that presage ill health by enlarging and clarifying the concept of the forces that affect health [60]

a. Focus on the pathways and trajectory from root factors to poor health outcomes to provide a basis for effective action

b. Reduce exposure to hazardous conditions in homes, workplaces and communities to reduce disproportionate risk exposure for people of color.[61]

c. Recognize the context in which behavior takes place in order to create opportunities to change social and behavioral norm negatively affecting health.[62]

3. Support Culturally Appropriate Outreach Campaigns

a. Fund, develop and implement culturally appropriate outreach campaigns to ensure all cultures have the full array of information, prevention and acute care services, with an emphasis on preventing and treating diseases that have a higher ethnic prevalence.

b. Conduct an inventory of existing programs. Expand the reach of successful programs and use them to develop new programs.

2. ORAL HEALTH

BACKGROUND[63]

While the good news is that tooth retention among older age groups has increased in recent decades in the United States, this puts them at greater risk for cavities and gum disease. Seniors still have the poorest oral health of any age group and have the most widespread disease in the population. Seniors have a 300% higher rate of cavities than children do. A 1999 National Oral Health Surveillance System report found that in California only 18.5 % of persons 65 and over have lost all of their permanent teeth, but 94% of adults age 18 or older have evidence of treated or untreated tooth decay. [64]

Twenty-five percent of persons aged 65-75 have severe gum disease that can be associated with the following factors:

- Receding gums, because unlike the crowns of teeth, exposed root surfaces are missing the protective layer of enamel that guards against tooth decay and disease.

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[60] Rachel Davis, MSW and Larry Cohen, MSW. Strengthening Communities: A Prevention Framework for Eliminating Health Disparities. Oakland, California: Prevention Institute. Prepared for The California Endowment, July 25, 2003. Page 31.

[61] Davis and Cohen. Page 30

[62] Davis and Cohen. Page 30

[63] Excerpts from the California Commission on Aging's *Statement of Findings, Senior Related Health Issues*. Sacramento: Planning for an Aging California - An Invitational Forum, April1-2, 2003.

[64] Oral Health in America: A Report of the Surgeon General. Washington, DC: Department of Health and Human Services, US Public Health Service, 2000.

- Men are more likely than women to have this problem.
- Persons with non-insulin dependent diabetes are three times more likely to get gum disease.
- Smoking also has an adverse effect on oral health.
- Over 600 medications increase the risk of oral disease.
- Dry mouth, often caused by medications, is another significant cause of dental disease and can lead to root deterioration.
- Periodontal diseases are linked to other health issues including osteoporosis.

Dental disease is one of the most untreated of all diseases. Donna E. Shalala, former Secretary of Health and Human Services stated "that ignoring oral health problems can lead to needless pain and suffering, causing devastating complications to an individual's well-being with financial and social cost that significantly diminish quality of life and burden American society." [65]

Most older adults (70 %) are able to get to the dentist. About 14% community dwelling elderly have chronic health conditions that result in major mobility limitations. Often homebound, these seniors often face insurmountable dental access barriers. In one study of older adults receiving home health services, the majority reported their oral health was fair to poor. Nearly 80% reported a perceived dental need. Twenty-six percent reported having been to the dentist within the past two years, and 40% reported having not been to the dentist in more that 10 years.

Other groups of older adults with functional limitations include those living in residential care or nursing facilities. Although regulations require nursing facilities to meet residents' oral health needs, these seniors may not have ready access to dental care. A review of oral health studies of institutionalized elderly published between 1970 and 1989 by Berkeley, *et al*, described the compromised oral health status of nursing home residents. Up to 70% of the residents had unmet oral needs, exhibiting high rates of being completely edentulous, having poor oral hygiene, periodontal disease, and soft tissue lesions.[66]

Most nursing homes (almost 70%) reported that they did not transport their residents to outside dental clinics except for emergencies due to transportation difficulties and access barriers that exist in dental office. Nursing homes and private dental offices generally have inadequate access, facilities and equipment to serve this population, creating a significant dental access barrier.

Permanent dental offices located within nursing homes, when they exist, generally do not have sufficient equipment to provide primary dental care. Such basic equipment as an x-ray machine and developer are frequently not available. Although a few permanent dental clinics within nursing homes have adequate equipment, they often do not have the portable equipment necessary to serve bedridden residents. Some bedridden residents cannot be transported or

[65] Oral Health in America.
[66] Oral Health in America.

transferred to a dental chair even if located within the nursing home. Like the homebound, these residents must have access to portable dental services in order to receive dental care at their bedside.

Many long term care facility residents suffer from Alzheimer's disease and other types of dementia. These residents are often profoundly confused and disoriented and must often be sedated for dental care, even to do an adequate oral examination or dental cleaning. Because of their age, and the presence of multiple medical problems and medications, sedating these residents must be a cooperative effort between the physician, nursing staff, and dentist. At the nursing facility where the medications most appropriate for each patient are available, and if on-site dental care is provided, the nursing facility staff can administer the sedation and help monitor the patient both before and after dental treatment.

Thus, by providing dental care that is integrated into overall care at the nursing facility, a very large group of residents with functional and/or cognitive limitations can gain access to primary rather that emergency dental care. Currently, there are no state-funded programs that make oral health education or mobile dental services available to homebound seniors or those in nursing homes.[67]

THE VISION - In the year 2020…

Dental care is no longer the hidden imperative for seniors. Dental care is covered by comprehensive insurance and includes dental coordinators who provide referrals to seniors for screening and prevention services and referral to appropriate dental and medical services.

As with the nurse practitioner program, the dental alternative practice programs have expanded access to dental services. Professional volunteers are working with community-based programs and have expanded dental services to assisted living and nursing home residents.

Improved access to dental care has made the positive relationship between oral health and physical health more clear.

ORAL HEALTH CARE RECOMMENDATIONS

1. Educate

a. Develop intergenerational programs that encourage seniors to educate children about achieving good health through healthy behaviors, healthy choices, and health management strategies.

[67] California Commission on Aging Minutes, Field Public Discussion, June 5, 2002, Ontario, Ca, Dr. Paul Glassman, Dean, University of the Pacific (UOP) School of Dentistry, Presentation on Oral disease among seniors, Eliza Chavez, Dentist and Instructor, UOP School of Dentistry, Presentation on Oral Disease and Effects on Senior Health Care.

2. Increase Participation

a. Subject to the availability of resources, create incentives to increase the number of dentists and other dental professionals participating in the state Denti-Cal program.

3. Home Dental Care

a. Identify and provide incentives for dentists and other dental health professionals to serve homebound and nursing home patients; subject to funding.

b. Outfit mobile dental vans to offer free clinics.

4. Support Alternative Practice

a. Create more educational programs in CA to prepare Dental Hygienists for the Registered Dental Hygienist in Alternative Practice license.

5. Form Coalitions

a. Encourage Area Agencies on Aging, health programs such as the Preventive Health Care for the Aging, senior nutrition programs, senior centers, senior housing, and adult day care programs to form coalitions to provide and promote older adult oral health education and prevention programs.

6. Provider Training

a. Require training on Oral Health Care for care providers including family caregivers, administrators and staff of residential and nursing care facilities for older and disabled persons, particularly in assisting in oral health care for persons with dementia.

7. Promote the Dental Coordinator Model

a. Promote the use of Dental Coordinators who work with seniors on: oral health care promotion, establishing systems for screening and referral, and facilitating linkages between medical facilities and dental services.

8. Add Oral Health to Existing Programs

a. Encourage existing Older Adult Health Programs/ Centers to include more oral health screening and oral health education in their programs.

9. Fluoridation

a. Encourage continued efforts at fluoridation of water in California communities and education about the positive aspects of fluoridating local domestic water.

10. Increase Accessibility

a. Increase access to dental services and offices for the frail elderly and persons with disabilities. Access improvements should address mobility, communications and alternative print brochures.

3. ALCOHOL AND CHEMICAL DEPENDENCY

BACKGROUND[68]

Alcohol, prescription drug and other drug problems among older adults have been identified as one of the fastest growing health problems in the country, although the situation remains underestimated, under identified, under diagnosed and under treated.[69] The national Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that alcohol and prescription misuse affects up to 17% of older adults. Prevalence estimates from community surveys of problem drinking among older adults have ranged from 1%-15%.[70] Because there is wide variation among prevalence rates based on sampling methodology, the number of older Californians who need attention for problems with respect to alcohol, prescription drugs, and other drugs may range from 47,000 to a staggering number of 2,726,000.[71]

Prescription medication misuse is the most common form of drug abuse among older persons. The elderly make up 11% of the U.S. population, yet they account for 25% to 33% of the prescription drugs and at least 25% of all over-the-counter medications used each year.[72] Lack of knowledge about both prescription and over-the-counter medications, drug interactions, failure to follow directions in taking medications, failure to pay attention to label warnings, and the danger of medication and alcohol interactions are all potential problems.[73]

In 1990, the total estimated economic cost of alcohol problems in the United States was $105 billion. Of that total, $1.165 billion was spent for direct costs to nursing homes, $3.690 billion to specialty organizations, $4.882 million to short stay hospitals, $255 million to office based physicians, and $128 million for social welfare administration (Rice, et. al.). However, alcohol-related problems for older adults are under treated.[74] This results in a higher hospitalization rate for alcohol-related problems than for myocardial infarction (i.e. “heart attack”).

Although the cost-effectiveness and efficacy of interventions for older adults at all levels of misuse and abuse has been established, few policies exist that reflect this knowledge. Few national, state or local policies exist to direct program develop in

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[68] Excerpts from the California Commission on Aging *Statement of Findings, Senior Related Health Issues*. Sacramento: Planning for an Aging California: An Invitational Forum, April1-2, 2003.
[69] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). Washington, DC: Center for Substance Abuse Treatment, 1998.
[70] Blow, F. (1998) Substance Abuse Among Older Americans (DHHS No. (SMA) 98-3179). Washington, D.C.
[71] Patrick Cullinane, MS., *Substance Abuse and Older Adults*. San Francisco: American Society on Aging, 2003
[72] Patrick Cullinane, MS., Substance Abuse and Older Adults.
[73] Substance Abuse and Mental Health Services Administration (SAMSA), Fact Sheet: Just the Facts, ”Chemical Dependency and the Elderly”. Reprinted in the Family Cycle and The Family Circle: A Handbook for Healthier Living, Riverside County Office on Aging.
[74] Adams, W.L., Yuan, Z., Barboriak, J.J., and Rimm, A.A. (1993). *Alcohol-related hospitalizations of elderly people: Prevalence and geographical variation in the United States.* Journal of the American Medical Association, 270 (10), 1222-1225.

this area. The Older Californians Act makes no mention of alcohol and medication misuse, and programs funded under the Act either do not have policies to address these issues, or wide variations exist in how they are addressed. Additionally, Medicare reimburses some substance abuse treatments for older adults, but at a lower rate (50 %) than younger adults. [75]

SAMHSA found that alcohol is a significant, unrecognized, predisposing factor among the following adverse health issues for older adults: [76]

a. Falls and injuries
b. Medication adherence issues
c. Mental health issues such as depression, anxiety, suicide and family violence
d. Mental status changes such as confusion, cognitive loss, and delirium
e. Cardiovascular illnesses such as hypertension, heart disease and vascular occlusion
f. Endocrine illnesses such as glucose intolerance
g. Breast, esophageal and colon cancer
h. Neurological problems such as peripheral neuropathy, strokes, ataxia, and dementia
i. Gastrointestinal illnesses such as diarrhea, incontinence, liver failure, and abdominal pain.

Alcohol use disorders are frequently one of a number of co-occurring illnesses in older adults. Alcohol use can not only cause disease, but its interactions with other physical conditions can also increase symptoms and make illness treatment resistant.

THE VISION - In the year 2020…

A multi-media campaign to limit the use of alcohol by older adults is a success. Of similar success is the campaign addressing the overuse of prescription drugs. An unexpected benefit of the reduced inappropriate use of alcohol and medication has been a significant cost savings to older adults, health plans and to government. Quality of life has been improved for a significant number of older adults and their families.

These positive outcomes are being maintained through health education and community services that offer a full range of alcohol and chemical dependency programs particularly geared to the needs of older adults.

[75] Cullinane, Substance Abuse and Older Adults.
[76] U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment. (1998) *Substance Abuse Among Older Adults.* Treatment Improvement Protocol #26, Washington, D.C.

ALCOHOL AND MEDICATION MISUSE RECOMMENDATIONS

1. Education – Group and Individual

a. Develop funding for alcohol and chemical dependency education and awareness campaigns targeted to seniors. Include screening and referral services.

1) Offer education, screening and referral programs in appropriate settings such as senior housing, senior centers, and other senior organizations. Also offer health fairs and Senior Awareness Day activities.

- Work with businesses to give time to pharmacists to come to senior centers to teach about drug use and misuse.
- Take care to offer programs in such a way as to not embarrass persons seeking information or treatment. For example, make a alcohol and medication misuse one in a series of "brownbag" lunch presentations.

b. Providers of health and wellness services should to raise awareness among clients of the potential negative health consequences of alcohol use with their medications.

c. Utilize state licensure processes for treatment facilities to encourage facilities, programs and staffing that are consistent with the needs of older adults.

2. Financing

a. To the extent that they exist, eliminate age and socio-economic inequity for reimbursement for substance abuse treatment.

3. Direct Services

a. Subject to available resources, enhance the ability of California Department of Alcohol and Drug Programs to pursue program development for senior alcohol and drug recovery services as the demand for services to the population increases.

b. Address depression and suicide in alcoholism programs for older adults.

4. MENTAL HEALTH

BACKGROUND

Excerpts from a report by Brian Kaskie and Susan Ettner [77]

The United States Surgeon General (2000) recently proclaimed that mental health is fundamental to overall health and well-being, and the effects of mental illness can be just as detrimental and disabling as cancer or any other serious health problem.

[77] Brian Kaskie, Susan Ettner. Promoting Mental Health, Preventing Mental Illness and Providing Effective Psychological Treatment to California's Aging Population. Berkeley: California Policy Research Center, University of California, 2001

Mental illness impairs functional ability, limits occupational and leisure opportunities, lowers health status, and may be a source of stress and burden to significant others and caregivers. It has also been suggested that mental illness represents a significant cost to the older individual and to society. Lifetime earnings of an individual with mental illness may be diminished, and his or her out-of-pocket spending for specialized treatment can be substantial. Insurance providers allocate as much as 15% of their annual budget for mental health and substance abuse services, and employers are challenged by increased absenteeism and turnover among employees with mental illness.

Some types of mental illness, such as anxiety and depression, are less severe and manifest sporadically over the life course. Other types of mental illness, such as schizophrenia and dementia, are more serious and persistent. Older adults experience many types of moderate to severe forms of mental illness: anxiety, delirium, dementia, depression, personality disorders, schizophrenia, and substance abuse. Some older persons may develop mental illness in childhood or adolescence, and endure the illness over their life course. Other older adults may have no history of mental illness until they experience a late-onset disorder such as dementia.

The Epidemiological Catchment Area surveys conducted by the National Institute of Mental Health[78] indicated that the prevalence rate among persons 65 years and older was 5.5% for anxiety disorders, 2.5% for clinical depression, 1.7% for substance abuse and .02% for schizophrenia. Moderate to severe cognitive impairment among older adults reached 4.9%. The surveys further revealed that the diagnosis of cognitive impairment corresponded most often with dementia rather than another neurological disorder, limited education, or developmental disability.

Moderate to severe mental illness constitutes the third or fourth most debilitating health problem affecting older adults, and as the population continues to age, the number of older adults with some form of mental illness will increase. [79] Because the probability of being diagnosed with dementia increases with age, mental illness will probably become more common over the next 20 years as other chronic health conditions experienced by older adults, such as arthritis and heart disease, become more responsive to treatment interventions – resulting in increased life expectancy and the probability of acquiring dementia. [80]

Population aging and the imminent increase in the number of older adults with mental illness presents several challenges. If the prevalence rates of mental illness were used to measure the need for specialty mental health care, then the number of

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[78] Regier, D., Boyd, J., Burke, J., Rae, D., Myers, J., Kramer, M., Robins, L., George, L., Karno, M., and Locke, B. (1988) *One month prevalence of mental disorders in the United States: Based on the five epidemiological catchment area sites*. Archives of General Psychiatry, 45, 977-986.

[79] National Association of State Mental Health Program Directors. *Older Person Division Report*. Alexandria, VA: NASMHPD Research Institute, 1998.

[80] Manton, K., Corder, L., and Stallard, E. *Estimates of change in chronic disabilities and institutional incidence and prevalence rates in the U.S. elderly population from the 1982, 1984 and 1989 national long term care survey*. Journal of Gerontology (1993), 48, 153-166.

older Californians who currently require specialty mental health care exceeds 720,000. Between now and 2020, as the Baby Boomers age, the number of older Californians with mental illness is likely to reach 1.8 million.

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One's psychological health is recognized to be so essential to the quality of life, that pursuing education and/or treatment to increase it is as natural as maintaining one's physical health.

Prevention programs, which extend to educational and medical care settings, are designed to be culturally sensitive, cover a broad range of needs, and help persons of all ages:

- Recognize and adopt habits that reduce stress and depression
- Deal effectively with bereavement
- Detect warning signs and reach out to those at risk

A change of attitude has removed treatment barriers and has prompted the development and statewide expansion of an *Integrated System of Mental Health Care*. Numerous benefits have resulted including, elimination of funding silos, dramatically increased access to mental health services, greater balance between counseling and pharmaceutical treatment, culturally sensitive services and more.

The percentage of older individuals receiving mental health treatment and support services has increased dramatically.

MENTAL HEALTH RECOMMENDATIONS

1. Public Information Campaign to Combat Prejudice

a. Subject to available resources, develop a campaign targeted to Older Adults to combat the prejudice associated with mental illness. Partner with the National Mental Health Association.

2. Expand Efforts to Promote Mental Health and Prevent Mental Illness

a. Subject to the availability of resources, develop alternative funding for the expansion of community based promotion, prevention and recovery education and outreach programs for older adults with mental illness.

b. Identify and incorporate mental health prevention programs considered to be "best practices" that include:

1) Relaxation training
2) Stress management
3) Memory training
4) Bereavement support
5) Outreach services to identify older adults at-risk for mental illness
6) Training to help service providers recognize depression and anxiety in older adults

7) Counseling programs that are most effective in preventing suicide
8) Implement practices already being used in some counties to provide emergency shelter
- Convene county mental health directors and key staff to present findings regarding promising practices
- Facilitate a 1-2 year "coaching" program in which counties that have implemented these strategies assist other counties in developing similar programs.

c. Extend promotion and prevention programs to medical settings to reduce psychological distress, depression, and health complications among older adult patients, including preventing the onset of delirium.

d. Remove barriers to implementing mental health screening and intervention management in medical settings to prevent worsening of mental health that can lead to suicide or other negative outcomes. Subject to available resources:

1) Change or improve reimbursement for providers
2) Fund pilot projects that include impact evaluations
3) Remove barriers and identify best practices that in the long run provide for cost savings (both to the medical provider groups, to insurance carriers, and to life-benefit of the individual.)
4) Provide incentives to medical clinics that do quality assurance improvement projects.

e. Staff behavioral health professionals in primary care/out-patient settings (i.e. become part of the on-site team).

3. Develop a Statewide Older Adults System of Mental Health Care.

a. A statewide system of mental health care should be based on the County Mental Health Directors' Association (CMHDA) *Older Adult System of Care Framework*[81] that has been circulated throughout California. Recommended activities described in that document should be prioritized so that first funds are spent on most critical needs.

1) Incorporate findings on best practices from the Older Adult System of Care Demonstration Project. These practices increase access to mental health services for older adults and improve the quality of services.
2) Every California county must have dedicated adult mental health programs with uniform quality standards and program consistency.

b. Local Comprehensive Plans should have an element on Psychiatric Emergency/Crisis Intervention.

1) The component should include emergency crisis intervention options for older adults who are exhibiting severe psychiatric and/or behavioral symptoms and/or dementia. The availability of these alternatives would potentially alleviate some emergency room visits, hospitalizations and inappropriate incarceration in jails.

[81] Position Paper on: *Older Adult System of Care Framework*, adopted March 15, 2001. Sacramento: California Mental Health Director's Association.

c. Subject to available resources, the California Department of Mental Health should enhance efforts to target services to the aging population, collect data on the provision of care, and evaluate the outcomes of service delivery.

4. Depression and Suicide Prevention

a. Subject to available resources, expand and establish programs that increase public awareness and apply diagnostic screening for depression in seniors.

b. Promote and implement depression and suicide prevention strategies:

1) For nursing facility residents
2) For those living at home, including potentially suicidal couples
3) For people with dementia

c. Educate front-line workers (i.e. postal carriers, in-home support service providers) to look for warnings of potential suicide and how to respond appropriately.

5. Training for First Responders

a. Enhance training programs for all “first responders” (e.g., law enforcement, fire department, paramedics, clergy etc.) to include:

1) Strategies for identifying, interacting, and making referrals of older adults who may be suicidal, suffering from depression, dementia and other mental health issues.
2) Training around senior alcohol and chemical dependency issues.
3) Periodic review and update of new law enforcement officer training courses on " Persons with Disabilities" to ensure current strategies are being taught.

6. Work to Improve Federal Medicare Policies (See Federal Policy element)

7. Facilitate Access to Mental Health Services in Underserved Areas

a. Subject to available resources, provide incentives, including additional education, for existing health ands social service professionals to specialize in geriatrics.

b. Consider adequate access to public transportation when locating services.

5. CHRONIC ILLNESS, PALLIATIVE AND END-OF-LIFE CARE

BACKGROUND

Excerpts from report authored by William Satariano and Valentine Villa [82]

Prevalence refers to the number of people alive with a particular condition. In

[82] William Satariano and Valentine Villa. *The Health Status of Older Californians*. Berkeley: California Policy Research Center, University of California, 2001.

California, statewide prevalence data are obtained from the Behavioral Risk Factor Surveillance System, as well as special studies conducted by academic institutions and private research groups. Osteoarthritis, cataracts, and diabetes are highly prevalent conditions in older populations. The clinical and public health significance of osteoarthritis and cataracts is not captured in mortality or incidence statistics, since they are not lethal conditions, nor is there is a definitive time of onset. Osteoarthritis and cataracts, however, have a significant impact on the level of functioning and quality of life of the older population.

Arthritis

Although there are no current data on the prevalence of arthritis in California, there are age-specific prevalence estimates of arthritis from Arizona, based on the data from the Behavioral Risk Factor Survey.[83] The prevalence for this condition increases steadily with age. Over a third of Arizona residents aged 65 to 74 (38.3%) and over half aged 75 and older (52.0%) report currently having osteoarthritis. The condition is more likely to be found among women and those with fewer years of education.

Cancer [84]

Cancer of the female breast and prostate cancer are the two most common forms of cancer diagnosed among female and male residents of California. The incidence rates for female breast cancer and prostate cancer increases with age. For prostate cancer, the increase in the age-specific incidence rate is greater than for any other form of cancer. Lung cancer is the leading diagnosed cancer among men and women combined. The lung cancer incidence rate in California decreased by 19% among men over an eight-year period, with decreasing rates among men in all four major race/ethnic groups. The decline in age-adjusted incidence rates for lung cancer was less among female residents than for male residents of California (7% vs. 19%). Cancer of the colon and rectum is the third most commonly diagnosed in California. The age-adjusted incidence rates for this type of cancer also declined for both men and women between 1988 and 1995, in this case, by 15%. Overall, African-American males are the most likely to develop cancer in California, a pattern found nationally. In 1995, the overall cancer incidence rate among African-American males in California (564.4 per 100,000) was 25% higher than among non-Hispanic white males (442.5), who had the next highest rate.

Diabetes

Diabetes is also a significant public health problem in older populations. Nationally, it is estimated that approximately 11 to 12% of the population aged 65 and older report that being told by their physician that they have diabetes. Put differently, 41% of

[83] Prevalence of Arthritis – Arizona, Missouri, and Ohio, 1991-92. Behavioral Risk Factor Surveillance System: Reprints from the MMWR 1990-98. Atlanta, GA: National Center for Chronic Disease Prevention and Health Promotion, 1999.

[84] *Cancer in California*, 1988-1997. Sacramento, CA: California Cancer Registry, California Department of Health Services, 2000.

those with diabetes are 65 and older.[85] There are also significant differences by race and ethnicity. The prevalence is significantly greater in Hispanic and African-American populations. Results from the National Health and Nutrition Examination Survey (NHANES) study, based on both laboratory and self-report data, indicate that in age group 65 to 74, the prevalence of diabetes was 17% among non-Hispanic whites, 25% among African Americans, and 33% among Mexican Americans.[86] Although Mexican-American women aged 45 to 54 had a higher prevalence of diabetes than Mexican-American men of the same age, there was no gender difference among older Mexican-American men and women. Complications associated with diabetes include blindness, nerve damage, and kidney disease. Other problems include retinopathy, glaucoma, cataracts, lower-extremity dysfunction, and depression.

Alzheimer's

Alzheimer's disease and other dementias also represent an increasingly prevalent condition among older populations.[87] Everyone over 65 is at risk, regardless of race/ethnicity, gender, or socioeconomic status.[88] It is estimated that approximately 10% of people 65 and older and 47% of those 85 years and older have Alzheimer's disease. The risk of the disease appears to be slightly greater in women than men. The risk is also elevated among those of lower educational level and lower socioeconomic status. One study indicated that the prevalence of Alzheimer's disease was greater among African Americans and Hispanics than Non-Hispanic men and women.[89] It is estimated that within the next 50 years, the prevalence could be expected to increase by 3.7%, to 8.64 million people in the United States. In California, more than 500,000 persons are currently afflicted with Alzheimer's—this number is expected to swell to more than 827,000 by 2025.[90]

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While chronic disease has not been eradicated, one remarkable effect of early intervention and self-management strategies has been that the impact of these conditions on seniors' daily lives has been reduced. Medical and social service funding have been integrated so that programs treat the whole person. Coalitions have been formed at the state and local level addressing the various causes of chronic illness. The synergy created from this collaboration has made it possible for seniors to better manage their own conditions and remain in their own home.

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[85] Diabetes Surveillance, 1999. *Prevalence of diagnosed diabetes, per 1000 population, by age, United States, 1980-1996, National Health Interview Survey*. Centers for Disease Control and Prevention, National Center for Health Statistics.

[86] Black SA, Ray LA, Markides KS. *The prevalence and health burden of self-reported diabetes in older Mexican Americans:* findings from the Hispanic Established Populations for Epidemiologic Studies of the Elderly. American Journal of Public Health 1999, 89:546-552.

[87] Albert MS, Drachman DA. *Alzheimer's' disease: What is it, how many people have it, and why do we need to know?* Neurology 2000, 55:166-168.

[88] Alzheimer's Disease and Related Disorders Association, Chicago, 1999.

[89] Hargrave R, Stoeklin M, Haan M, Reed B. *Clinical aspects of Alzheimer's disease in black and white patients.* Journal of the National Medical Association 1998, 90:78-84.

[90] Alzheimer's Disease and Related Disorders Association, Chicago, 2002.

Geriatric care management teams provide comprehensive treatment plans for persons with chronic illness that addresses their acute and chronic health issues and provide follow-up and management, including the needs of family caregivers.

Increased understanding of the nature and course of Alzheimer's disease and dementia has broken down previous service funding barriers for mental health services. Private and public funding sources now enable persons with Alzheimer's disease or related dementias to live and receive care in the least restrictive environment.

CHRONIC HEALTH CARE RECOMMENDATIONS

1. Comprehensive Care

a. Develop and expand comprehensive care models that treat the whole person by investing in health promotion, effective rehabilitation, and cost effective social and health care services and supports. Subject to the availability of resources, develop financing methods that provide financial incentives for providers to use this approach.

b. Integrate funding to enable treatment of conditions with both medical model (disease) treatment and social model (functional support) components; treat the whole person.

2. Build Public-Private Coalitions

a. Encourage coalitions between the appropriate state departments, the Medical Board, the California Medical Association, the California Association of Geriatric Medicine, the California Dental Association, the California Pharmacy Association and other stakeholder organizations to better meet the needs of older and disabled Californians.

3. Chronic Health Self-Management

a. Pilot new person-centered care models that empower older adults to better manage their own chronic health conditions, whether that is arthritis, diabetes, stroke rehabilitation or other long term health conditions.

1) Important components in this effort include increasing health literacy, an improved understanding of the individual's health condition, informed choice of treatment options and information on how and when to seek medical assistance.

2) Pilot new care models in which providers offer chronic care management to individuals, particularly those with dementia, who are incapable of managing their own chronic health conditions, and need that assistance.

4. Fund and Conduct Research in the Following Areas:

a. Improving culturally appropriate assessment and diagnostic protocols, particularly for addressing the need for culturally appropriate assessments.

b. Developing new treatment modalities and medications that slow disease progression, improve treatment of symptoms, and/or reverse the course of disease.

c. Coordinate efforts to obtain better data on the disability rates associated with chronic conditions by race, ethnicity and age group.

d. Develop specific new approaches for addressing racial and ethnic chronic health disparities across sub-populations of aging Californians.

PALLIATIVE [91] AND END OF LIFE CARE RECOMMENDATIONS

1. Expand Public-Private Partnerships to Support the Education and Training of Health and Social Service Professionals in the Specialty of Palliative Care [92]

a. Create a cadre of academic faculty trained in the principles of palliative care at all of the state's medical schools, teaching hospitals and schools for related medical professionals (e.g., social workers, nurses, etc.).

1) This training curriculum must address multicultural issues as they relate to palliative and end-of-life care since the experience of illness and death is profoundly affected by cultural background.[93]

2) This training curriculum should include non-cancer diagnoses, persons with dementia, and working with caregivers as it relates to palliative care.

b. Develop quality of care protocols and indicators for palliative and end-of-life care, including pain management that is not necessarily limited to the end-of-life timeframe.

c. Support the efforts of statewide coalitions, such as Californians for Compassionate Care Consortium, seeking to educate the public and health care providers on the purpose and value of hospice care.[94]

2. Restructure Reimbursement Systems for Palliative Care

a. Realign reimbursement systems to cover individuals with certain chronic diagnoses that are not "terminal" but need palliative care (e.g., chronic obstructive pulmonary disorder).

b. Reimbursement systems should consider the projected mortality rates for specific diseases and examine the "six month life expectancy" restriction on hospice reimbursement.[95]

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[91] Palliative care is a specialty dedicated to relieving pain and suffering.

[92] Robert N. Butler, MD, Diane E. Meier, MD, James P. Nyberg, MPA. *Palliative Care Academic Care Awards – A Public-Private Partnership to Improve Care for the Most Vulnerable.* International Longevity Center-USA, Ltd., 2003, page iv. The authors note that public funding sources must be found that will expand private philanthropy in order endow professorships, curriculum development, capital investments, and other initiatives in palliative care. Up to this point in time major funding for this field has been private philanthropy. Major funding runs out in December 2003 leaving a major void in support for new faculty.

[93] *Multiculturalism and End of Life Care: A Two-Day Training Course for End-of-Life Professionals*. Access to End-of-Life Care, San Francisco State University, College of Extended Learning. 2003.

[94] CDA reports that currently, only one out of three individuals appropriate for hospice die in hospice care. A third of the hospice clients die in the first week, which significantly limits the value of the hospice benefit to them and their families.

[95] June Lunney, MD. Patterns of Functional Decline at the End of Life. JAMA, May 14, 2003

6. LONG TERM CARE

BACKGROUND

Excerpts from a report by Charlene Harrington, Robert Newcomer, Patrick Fox, M. Christine Tonner, Valerie Wellin and Martin Kitchener [96]

The range and complexity of public long term care (LTC) programs provided in California is enormous. In l998, total public LTC expenditures for the aged and adults in California were at least $9.2 billion.

Each public program operates with different federal and state legislative mandates, administrative traditions, types of administrative personnel, constituency and target groups and funding sources. The funding sources for public LTC programs are particularly complex. The Medi-Cal program paid for $3.7 billion, or 40% of the total $9.2 billion LTC expenditures for younger and older adults. The Medi-Cal programs for the aged and adults are housed in four state departments—the California Department of Health Services (CDHS), the California Department of Social Services (CDSS), the Department of Developmental Services, and the California Department of Aging (CDA)—but CDHS retains an oversight responsibility for its Medi-Cal LTC programs. In addition to Medi-Cal funds, state general funds are used in combination with other federal funding (e.g., Social Security Act, Title XX and Older American's Act funds) to pay for LTC. The intricacies of funding source requirements vary by program and contribute to challenges in program coordination.

The state LTC programs for the aged and adults have devolved to different government agencies and private organizations. Some CDHS LTC programs are coordinated by CDHS at the state level, but most institutional, home and community-based services are delivered by private providers throughout the state. These are generally not coordinated by CDHS. CDSS uses the 58-county social service/ welfare agencies to operate most of its programs. CDA uses the 33 public and nonprofit Area Agencies on Aging (AAA) to administer the Older Americans Act. Some of these public and private agencies may have little knowledge or interaction with other programs that administer LTC at the local level. These different structures make coordination of services more complex.

[97]California has been a leader in providing services to support the full integration of persons with disabilities in community life. The U.S. Supreme Court decision in *Olmstead v. L.C.*, 119 S.Ct. 2176 (1999), provides a legal framework for California's effort to help individuals with disabilities live in the most integrated setting appropriate to their needs. Under the Court's decision, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: 1) the state's treatment professionals

[96] Charlene Harrington, Robert Newcomer, Patrick Fox, M. Christine Tonner, Valerie Wellin, and Martin Kitchener. Excerpts drawn from *Publicly Financed Long Term Care for the Aged in California*. Berkeley: California Policy Research Center, University of California, 2001.

[97] Information provided by the California Department of Aging, Sacramento, 2003.

reasonably determine that such placement is appropriate; 2) the affected persons do not oppose such treatment; and, 3) the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are also receiving disability services provided by the state.

Services that support full integration in the community were born out of the independent living and disability rights movement. Key to integration is the availability of personal assistance to avoid the institutionalization of individuals who require assistance with activities of daily living. As a result of two decades of state legislative and budgetary actions, California has the largest consumer directed, personal care program in the country. From 1999 to 2001, expenditures for this program almost doubled to $2 billion, as increased worker wages and benefits have been phased in. California's Olmstead Plan challenges the state to develop even more opportunities for individuals with disabilities who desire to live in the community. (See Appendix H for the Recommended Future Actions Section of California's Olmstead Plan.)

The Multipurpose Senior Services Program (MSSP) is one of several Home and Community-Based Services (HCBS) waivers under the Medi-Cal program. MSSP is the aging-specific home and community-based program serving Medi-Cal beneficiaries who are nursing home certifiable but seek to remain in their own home with assistance. Between 1999 and 2001, 19 new MSSP program sites in various parts of the state were funded. Approximately 12,000 older adults are currently served through this Medi-Cal wavier program

The acute-care model has been the prevailing paradigm in nursing facility care for decades. This approach is essentially a model in which facility staff do what they determine to be appropriate for residents' health and safety. Redesigning this model is critical to humanizing the nursing facility (e.g., making it a home where nursing care is provided) and making these facilities more integrated into the community as well. Changing the culture of the nursing facility empowers residents with self-direction, choice and a new purpose in life. A new kind of nursing "home" is being developed that is based upon a social model. It emphasizes "resident-centered" life and care, where the culture within the facility is centered around the resident as a "whole person." In these communities, residents have control over their daily lives. Direct care staff are empowered to encourage that self-direction and help provide for residents' needs – social and personal as well as medical.

Models such as the Pioneer Network and Eden Alternative advocate for the formation of partnerships among all long term care stakeholders – residents, families, facility staff, advocates and surveyors. Rather than viewing the regulatory process as a threat or obstacle to culture change, facilities that make use of these types of partnerships are able to realize both the spirit and letter of the federal Nursing Home Reform of Act of 1987 (Omnibus Reconciliation Act (OBRA) '87).

In addition to looking at a facility's compliance with regulations, state and federal surveyors and regulators must be able to apply these regulations to the broader picture of how a facility is applying regulations. This not only ensures quality of care, but also quality of life in the overall administration of a facility.

The Linkages Program provides care coordination and a limited purchase of services for adults of all ages who have disabilities and are not eligible (or are on waiting lists) for other programs. This program is solely funded by state general fund. In 1998 the budget for this program was just over $2 million, which has increased to $8 million in 2003. This program serves approximately 4,000 adults with disabilities.

[98]Assembly Bill 452 (Mazzoni), passed and signed by the governor in l999, provides for a state Long Term Care Council within the California Health and Human Services Agency. The aim is to coordinate LTC policy development and program operations, and to develop a strategic plan for LTC. This interdepartmental and agency council should address some of these coordination issues.

Key Facts

- California served as many as 4.8 million aged and adults in its public programs (although some of these may be counted more than once) in l998. The majority (92%) of total LTC aged/adult participants are living in the community, while only 8% were receiving care in institutions in 1998.
- California had about 131,923 nursing facility beds in free-standing and hospital-based facilities and served about 99,000 individuals on a daily basis. The total expenditures were over $5 billion in l998, and Medi-Cal paid for 64% of the total resident days and 45% of the total expenditures.
- The average Medi-Cal freestanding nursing facility payments per day were only 68% of private pay payments.
- In l998, the majority (55%) of the public LTC expenditures for the aged and adults ($5 billion) were for nursing facilities serving a limited number of individuals.
- In spite of the aging of the California population and the slow growth in nursing facility beds, the occupancy rates in nursing facilities are low (82.7%) and are declining. The trend probably reflects a growth in alternatives to nursing facilities and the strong preferences of individuals to live at home. It also reflects the growth of assisted living facilities licensed as residential care facilities for the elderly (RCFE).
- California has a large supply of residential care facilities (RCFs), and about 29% of the funding for RCF care is from Supplemental Security Income and State Supplemental Payments (SSI/SSP). The average SSI/SSP payment was only about $9,854 per participant per year in l998. Medi-Cal has not paid for residential care, so this is not an option for Medi-Cal beneficiaries at this time.

[98] Continuation of excerpts from Charlene Harrington, Robert Newcomer, Patrick Fox, M. Christine Tonner, Valerie Wellin, and Martin Kitchener.

- The largest number of LTC participants receive services from the In-Home Support Services (IHSS) program (214,845); 67% of the participants are in the Medi-Cal program. In l998, the IHSS program spent $1 billion and Medi-Cal paid for 78% (administered by the California Department of Social Services). IHSS provides important personal care services that allow individuals the opportunity for assistance at home. The program has relatively low annual costs per Medi-Cal participant ($5,722), compared to Medi-Cal freestanding nursing facility costs ($31,028). However, IHHS recipients are not required to meet a need for nursing home care.
- In l998, Medi-Cal spent $124 million on home health and hospice services (or 7% of the total) compared to $1.7 billion in expenditures by Medicare for home health and hospice in California in 1997.
- Home and community-based services (HCBS) 1915(c) waiver programs for the aged/adults are paid for by Medi-Cal and administered by the California Department of Health Services and the California Department of Aging. Five waiver programs served only 11,022 participants and spent only $66 million in 1997–98.
- The 1998 HCBS waiver expenditures for the aged/adults were about $5,986 per participant. This is substantially lower than those in Medi-Cal freestanding nursing facilities ($31,028), even though all waiver participants must meet the need criteria for institutional care. HCBS programs may not be offering sufficient services to prevent institutionalization.

Policy Options

Policy options for addressing these issues must be based on the following two premises: (1) even if California achieves the highest possible efficiency and effectiveness in its overall LTC delivery system, public and private LTC costs will expand dramatically during the next 40 years and (2) LTC outcomes emphasize community residency and quality of life.

Research conducted by the Minnesota Department of Human Services states, "The public seems preoccupied with the risks associated with delivering health and long term care. This leads regulatory bodies to respond to the public's concerns with more regulations aimed at protecting consumers from possible risks to their safety. These regulations may restrict the choices available to individuals and increase the costs to providers to deliver services.

"This mindset may be severely tested and challenged in the future in light of the baby boomers' preferences for choices in all parts of their lives, including health and long term care. More of these individuals are likely to want to continue living in their own homes, taking some risks in order to maintain a level of control over their life. However, the loosening of regulations will need to be balanced with the need to protect vulnerable individuals within service systems." [99]

[99] *Aging Initiative: Project 2030.* St. Paul: Minnesota Department of Human Services, 1998. Page 29.

Additional in-home and community-based support services are needed for adults with disabilities who want to live in the most integrated environment possible. Affordable residential and skilled nursing facilities will provide supportive and rehabilitative services to the growing population. Many more health professionals and paraprofessionals with training in gerontology and geriatrics are needed. Investing in a full continuum of long term care options will make it possible for older adults to live in the most independent and integrated environment possible.

Immediate action is needed to develop an adequate supply of personnel in homes, communities and facilities with the training and skills to respond to the needs of an increasingly diverse aging population. To increase the quality of such services, improved wages, benefits, and training are needed. In addition, families caring for elderly relatives need more assistance to handle the emotional, physical and financial demands of long term caregiving.

Overriding Long Term Care Principles
Several principles should drive long term care policy**:**

- Consistency with the Olmstead Decision
- Home vs. institutional focus
- Promote independence, choice, dignity
- Eliminate fragmentation, create one integrated long term care system that is seamless to the consumer
- Governance, funding and system integration
- Ensure service/workforce capacity adequate to meet projected needs

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From Long Term Care to Long Term Support
People used to equate long term care with nursing homes where frail elderly, unable to care for themselves, received assistance. Conceptually, the term has changed to long term support, recognizing that many different levels and types of support are needed to create choice and promote independence.

Long term support in 2020 is consumer directed and stresses "functional wellness." Physical and mental health is promoted and coordinated with the goal of enhancing quality of life. Recognizing that one size does not fit all and that older people need more than medical care, older people can choose an array of support services that help them to live meaningful, independent lives. Care Navigators work with personal support teams to assist at-risk individuals.

Community Based Care
No older person or individual with disabilities lives in an institution unless they chose to do so as they now have a full array of support options. Individuals and their caregivers are empowered to direct their own care and health promotion. They now have access to a broad menu of flexible services rather than a single facility-based service system of the past.

The old system involved multiple service pieces that operated independently despite their relationship to one another. Now these services are joined in a “long term support continuum" that offers medical and social support services to assist older people in their everyday lives - all of which are delivered at the community level.

A consumer directed model of care has been implemented which emphasizes the delivery of care with preferences and choice. Disabled persons in the community have the supports available to live satisfying lives. Consumer satisfaction has greatly increased and health outcomes have improved significantly.

Integration of the financing structures and delivery mechanisms brought about today’s flexible support system. This system provides broad consumer choices in types of services, options regarding *where* services are delivered, and assistive products and technology.

Such flexibility means that long term support in 2020 is truly “customer-driven," allowing older people to select and control the services they need, want and can afford. Flexibility also means greater support for family caregivers as they continue to provide the vast majority of the long term support needed.

Institutional Care

Thanks to the efforts of successful coalitions,[100] nursing facilities are now “homes” that provide nursing assistance and supervision to individuals who need skilled nursing care. These “facilities” no longer look like hospital floors. Schedules are built around the resident’s preferences and needs and all residents are encouraged to be as independent and involved as possible in activities within and outside the facility. Facility multi-use rooms and areas of the grounds are routinely used by outside community groups, integrating the community into the facility as well. Many nursing homes, especially in rural areas, provide community day services and emergency and scheduled respite for family caregivers.

Meeting the Needs of a Diverse Population

The long term support system is sensitive and responsive to the state’s great diversity and appropriately supports the care needs of different racial, cultural and ethnic groups. There are now sustainable service models to serve these populations. Providers have enhanced their ability to compete for customers based on their ability to appropriately customize their services and make them more accessible and user-friendly for people with different needs and expectations. As a result health disparities are rapidly disappearing.

[100] Examples of these efforts currently underway include the Nursing Home Pioneer Network and the Eden Alternative.

LONG TERM CARE RECOMMENDATIONS

1. Invest in Preventive Care and Self-Care Approaches

a. Invest in prevention with the goal of compressing morbidity and mortality among Californians as much as possible within the next 20 years.[101]

2. Ensure That All Long Term Support Programs are Consistent with the Olmstead Decision.

a. Balance programs and funding of institutional long term care with home and community based support services to enhance the opportunities for choice. Long term support must be responsive to individual consumer needs and choices.

b. Facilitate a dialogue with stakeholder organizations representing both older adults and adults with disabilities to discuss to discuss coordination in the implementation of this Strategic Plan.

3. Eliminate Fragmentation - Design a Consumer-Focused, Seamless Service Delivery System

a. Appoint a "blue ribbon" think tank team to participate in an "out of the box" policy development project to envision an entirely new model for California's long term support system based on consumer needs and without concern, during the exercise, for traditional, governmental/statutory and/or funding structures. Propose a new system based on the outcome of this exercise. A new system must incorporate:

1) Integrated information systems
2) Facilitating consumer access to information
3) A continuum of integrated access and service delivery options
4) "No Wrong Door" approach
5) Seamless access to services
6) Consumer directed care
7) Provide assistance in navigating long term care services
8) Integrated, streamlined and innovative funding strategies
9) Cultural diversity
10) Collaboration between state, counties and local providers
11) Collaboration between aging and disability networks
12) Ongoing evaluation of outcomes, quality and efficiency

b. Plan to implement a **Care Navigation System** that allows an individual to "go through any door" to get information and to access the long term care system. Utilize the existing CalCareNet system:[102]

1) Integrate multiple funding streams and streamline eligibility criteria to allow seamless access to services and make it easy to move from one program to another.

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[101] Charlene Harrington, Robert Newcomer, Patrick Fox, M. ChristineTonner, Valerie Wellin, Martin Kitchener. *Publicly Financed Long term Care Programs for the Aged in California*. Berkeley: California Policy Research Center – University of California, 2001. Page 32.

[102] Called for by SB 953 (Vasconcellos, 2002)

2) Break system fragmentation by facilitating consumer access to information and Services.
3) Provide assistance with assessment to determine the most appropriate and integrated care options.
4) Provide assistance in navigating the long term care services.

4. Care Management

a. Subject to funding, establish the Geriatric Comprehensive Care Management Program for persons over 60 with more than one chronic condition. Components of the program should include:

1) A continuum of integrated accessible service options
2) A nurse/social worker geriatric team as part of every primary health delivery system
3) Development of a care plan with the consumer that considers the person or caregiver's ability to follow the plan based on their mobility, cognitive status, mental health, medication management status, transportation and nutrition needs
4) Consideration of the needs of family caregivers
5) Early diagnostic tests for Alzheimer's

5. Expand Community Service Capacity, Access to Care and Care Options

a. Expand the continuum of community-based services inside and outside the home throughout the state including, but not limited to: care coordination/ navigation, home health, home aid, in-home supportive services (IHSS), independent living centers (ILC) and day care, including Adult Day Health Care (ADHC) and Alzheimer's Day Care Resource Centers (ADCRCs).
b. Expand public long term services to prevent unnecessary or inappropriate institutionalization.
c. Ensure hours/access to services that are adequate to meet minimum individual needs as well as accommodate all persons needing services.
d. Expand reliable transportation services for the frail elderly.
e. Expand and improve coverage of personal care services outside of the home.
1) Extend options for personal care attendants in the workplace.
f. Expand consumer training on hiring and managing homecare workers.

6. Enhance Security/Safety

a. Expand Adult Protective Services to ensure protection of one of California's most vulnerable populations from theft, neglect and abuse.
b. Improve in-home worker screening to ensure clients aren't subjected to abuse and theft. Give consumers informed choice in the screening process to ensure consumer control.
c. Provide long term care grievance processes and inform participants how to use the processes.

7. Legal

a. State standards should be established for county conservators so there is consistency in how conservators handle their responsibilities, particularly end-of-life decisions.

b. Education campaigns should include the importance of having a durable power of attorney for health care.

8. Build Quality into the Long Term Support System

a. Establish a quality assurance system for long term support services that is parallel to the quality assurance system in acute care. Funding could be tied to quality outcomes.

b. Improve the oversight of long term support service providers to improve the general quality of long term care.[103]

c. Improve the quality of services inside and outside the home.

d. Improve the quality and stability of the long term support service workforce. [104]

9. Stabilize Long Term Care Funding

a. Develop a "Money Follows the Person" model to provide resources for individuals to live in the community rather than an institution. Seek opportunities to increase resources and funding options.

b. Evaluate inequities in insurance and Medi-Cal reimbursement to providers.

1) Subject to the availability of resources, increase reimbursement rates to a level that will ensure adequate wages for care workers and quality care.

2) Subject to the availability of resources, allow drug coverage for treatment of Alzheimer's and related disorders.

c. Identify and remove the federal, state and local barriers that have delayed implementation of integrated long term care programs throughout the state.

d. Develop a co-pay or sliding scale rate structure or other financing options that enable individuals not eligible for Medi-Cal to receive the full range of home and community-based services and supports necessary to avoid institutionalization. This mechanism will ensure that services are available to all persons in need at all economic levels.

10. Ensure Caregiver Support

(See Family/Informal Caregiving recommendations, page 88)

11. Ensure Adequacy of Provider Training/Education

(See Higher Education recommendations, page 102)

[103] Harrington et al, CPRC. Page 30.
[104] Harrington, et al, CPRC. Page 31

7. FAMILY, INFORMAL CAREGIVING

BACKGROUND

Excerpts from a reports by Andrew Scharlach [105]

Families are the backbone of the state's long term care system. Family members provide the vast majority of the care needed by disabled elderly Californians, often at great personal sacrifice, saving the state billions of dollars a year in costs that otherwise would be required to pay care providers. Indeed, a 1997 study by the United Hospital Fund estimated that the care provided by families and other informal providers had an economic value of $196 billion nationally, or more than $20 billion in California alone.[106] Yet, relatively little is known about California's family caregivers, the adequacy of the care they provide, or the supports they need. Nor have family caregivers consistently been recognized as a key component of the state's long term care system and included in long term care planning efforts.

The Need for Care

Approximately 75% of community dwelling disabled elderly are cared for at home or in the community by family members or other informal care providers.[107] The availability of a family member to provide care has been found to be a major factor predicting whether or not a disabled elderly person can remain at home. In this way, family caregivers not only help to support the independence and quality of life of older adults, but also reduce the cost of care for individuals and for the state.

Prevalence of Caregiving

Analyses of data from the National Survey of Families and Households and the Survey on Income Program Participation estimate that between 24 million and 27.6 million Americans provide personal assistance to a disabled adult, representing 2.9 million Californians.[108] A survey conducted in 1996 by the National Alliance for Caregiving and the American Association of Retired Persons estimated that approximately 16% of households were currently providing assistance to someone age 50 or older,[109] representing about 1.75 million California households. It is estimated that by the year 2007, the number of caregiving households in California could exceed 4 million.[110]

Concern has been raised regarding the future availability of family members to care for increasing numbers of disabled elderly persons. In 1990, there were 11 individuals ages 50–64 for each elderly person age 85 or older, the majority of whom needed assistance on a daily basis. By 2030, it is estimated that there will be only 6 individuals ages 50–64 for every person age 85 or older. For each person ages 70–85, the number of biological children is expected to decline from its current level of

[105] Andrew Scharlach. *Family Caregiving*. California Policy Research Center, University of California, 2001.
[106] Arno, Levine, and Memmott, 1999.
[107] Liu and Manton, 1994
[108] Arno, Levine, and Memmott, 1999
[109] NAC/AARP, 1997
[110] NAC/AARP, 1997

about 2.5 to about 1.7 in 2030.[111] The decreased number of family caregivers is apt to be complicated further by geographic mobility, greater female workforce participation rates, and major changes in the composition and consistency of family groups.

Two-thirds of all caregivers also hold jobs. They are struggling to maintain their jobs and their own health. It's the start of a looming trend that demographic experts say will have lasting implications for employers. Already, an estimated $29 billion in productivity is lost by businesses each year because of workers' caregiving duties.[112]

Characteristics of Caregivers
The typical caregiver has been described as a married woman in her mid-forties who works full-time, is a high school graduate, and has an annual household income of $35,000.[113] However, 12% of caregivers are elderly themselves, providing care to disabled spouses, siblings, children and sometimes parents.

Employment
The 1996 national survey by the National Alliance for Caregiving and the AARP found that 64% of caregivers were working, 52% full time and 12% part time.[114] In 1982, by comparison, only 42% of caregivers were employed full time.[115] A study of family caregivers served by California's Caregiver Resource Centers (CRC) found that 53% of non-elderly individuals providing care to a brain-impaired adult also work outside the home. [116]

Gender
Women are more likely than their male counterparts to take on care responsibilities for disabled family members; indeed, 65% to 75% of all caregivers are female.[117]

Race/Ethnicity
Although the evidence is somewhat equivocal, there seems to be a slightly higher prevalence of caregiving among African American and Hispanic families as compared with white families.[118] Hispanic elderly are more likely than non-Hispanic whites to live in multigenerational households and have multiple family members involved in providing care.[119] Of the three racial/ethnic groups, white caregivers are the most likely to provide care for a spouse, Hispanics are the most likely to provide

[111] Wachter, 1998
[112] Information supplied by the Senior Worker Advocate Office, California Employment Development Department. Sacramento, June 2003.
[113] NAC/AARP, 1997, p. 8
[114] NAC/AARP, 1997
[115] Stone, Cafferata, and Sangl, 1987
[116] Feinberg, Pilisuk, and Kelly, 1999
[117] Barr, 1990
[118] Fredriksen, 1993
[119] Feinberg, Pilisuk, and Kelly, 1999

care for a parent, and African Americans are most likely to be caring for other family members or unrelated individuals.[120]

Family members are the primary providers and managers of community-based long term care for disabled older persons. Many of these family members experience substantial primary and secondary costs associated with providing care, including stress, health and mental health problems and work restrictions. In addition, questions have been raised about the ability of some families to adequately provide the high level of care needed by many older persons with severe disabilities.

Caregiving family members currently receive little organized support. Caregiver Resource Centers provide a variety of supportive services for family members caring for brain-impaired adults. However, the CRCs serve fewer than 15,000 people a year, reaching only a tiny fraction of the state's caregivers. The recently enacted National Family Caregiver Support Program is an important next step in developing programs to meet the needs of the state's caregivers.

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Caregivers receive special attention. Their role in supporting the physical and psychological well-being of their family members or close friends is recognized as the glue that holds the long term support system together.

Educational programs address:
- The course of chronic conditions
- Challenges unique to rural living
- Identification of "burn out" symptoms
- Self care strategies

Support groups and respite programs are well established in every county, including in rural areas. Physicians are tuned to the needs of caregivers along with the needs of their patients.

FAMILY, INFORMAL CAREGIVER RECOMMENDATIONS

1. A Family Centered Approach with Community Support

a. All state long term care policies and programs should have the explicit objective of a client or consumer centered approach with family support.[121]

b. Given the clear economic value of family support, expansion and better coordination of family-support programs is essential.

c. Implementation and evaluation of the Long Term Care Integration Pilot Program, Older Adult Systems of Care, Older Adults System of Mental Health

[120] National Academy on an Aging Society (NAAS). Challenges for the 21st century: Chronic and disabling conditions. Washington, DC: NAAS, 2000.

[121] Scharlach, Andrew. *Family Caregiving.* Berkeley: University of California – California Policy Research Center, 2001. Page 15

Care, Golden Challenge Grants, and augmentations to other programs such as Adult Protective Services should include explicit consideration of how these programs can support the well-being, needs and capabilities of families, as well as individuals.

d. Leadership from local and state governments and collaboration and coordination among formal (paid) and informal (family/friends) networks, public and private entities is needed to develop a more effective system.

2. Coordinate Local and Statewide Caregiver Programs

a. Subject to the availability of resources, ensure access to a full range of caregiver resources in every county in California with particular emphasis in the rural areas of the state.

b. Promote collaboration and cross-learning among the caregiver projects and organizations.

3. Assessment of Caregiving Needs and Resources

a. Assessment of caregiving needs and resources should be an integral part of care planning and service delivery efforts in all programs serving older adults, especially those designed to serve persons requiring home and community-based care. For example: In Home Support Services (IHSS), Multipurpose Senior Services Program (MSSP), and Linkages, as well as physical health and mental health programs serving vulnerable individuals.

4. Provide Appropriate Caregiver Education and Training

a. Education and training for family caregivers must include: training on interacting with physicians, training on specific care giving tasks, education about disease processes, problem-solving, self-care, stress, depression and coping techniques. These should be explicit components of programs serving elderly and disabled persons, health and mental health services, and caregiver-specific support programs.

b. Culturally appropriate training must be expanded to ensure that courses are offered in different languages. Build on the success of existing culture specific programs to help community organizations without such programs.

c. Training must be accessible with training available with American Sign Language (ASL) interpretation and materials/information available in alternative formats: Braille, Large Print, Computer Disk.

5. Ensure Caregiver Support

a. Medical standards of practice should be changed to ensure primary practitioners regard caregivers of the most vulnerable patients as patients themselves with ongoing needs.

b. Subject to the availability of resources, expand caregiver services/support in every county/region.

c. Provide Additional Support for Vulnerable Caregivers.

1) Intensive intervention efforts should be targeted to vulnerable caregivers, including those who are poor, socially isolated or who have health problems

of their own. Intervention should also target those who experience high stress levels, and care for persons with problematic behaviors, dementia, or a high level of daily dependency.

2) Interventions should include a combination of individual and family counseling, support and education, including problem-solving and behavior-management skills training, family counseling, disease-specific support groups and respite care.

3) In addition, information specialists in existing systems should be trained to recognize care giving issues and refer caregivers to appropriate resources.

4) Recruit and train home care providers for caregiver respite.

6. Establish an Integrated Caregiver Information System as an Element of the Care Navigation System (Also see the Infrastructure element)

a. Subject to the availability of resources, develop an integrated, universal information system that includes:

1) Profiles of caregivers and care receivers, including local, regional and statewide information regarding the characteristics and needs of a representative sample of caregivers.[122]

2) Client specific data, service use and client satisfaction data from Caregiver Resource Centers.

3) Planning and Service Area (PSA) of the Area Agencies Client-Specific Data and Service Use Common Data Set, incorporating client-specific information on caregiver and care receiver characteristics with unduplicated counts of service utilization for caregiver support services.

4) PSA-Based Client Satisfaction Profile, including service satisfaction and client outcome information from a representative sample of clients using caregiver support services.

[122] The California Caregiver Resources Centers have the oldest, most comprehensive statewide longitudinal database on family caregivers.

G. Infrastructure

1. Data Systems
Comprehensive, Consolidated, Longitudinal

BACKGROUND

Comprehensive Database on Aging Californians
Frank W. Neuhauser, Henry E. Brady, and Jason S. Seligman [123]

The SB 910 legislation mandated the development of a plan for a longitudinal database of Californians. The full CPRC report by the above authors offers a comprehensive plan for achieving that goal.

The state already gathers data that are rich in detail and have implications for public policy, and which can be linked to create a longitudinal portrait of aging Californians. However, improving data quality and developing it into an integrated database will require the cooperation of several state and local agencies, local-area providers of aging services, as well as some additional state resources to expand research efforts.

A number of approaches have been considered for creating such a portrait. One approach is the creation of a longitudinal survey of successive age cohorts, similar to the federally financed Health and Retirement Survey (HRS) of a national sample of aging Americans. This kind of survey would provide a rich and detailed picture of California's aging population, but only after a number of years and substantial expense. Another approach is to assemble past, current, and future administrative data relatively quickly and inexpensively to yield a more-limited picture with a number of gaps.

Also, the state could assemble both current administrative and survey data and fill in the gaps with additional administrative and survey resources. This approach, to be referred to as the Comprehensive Database on Aging Californians, could create a detailed data resource relatively quickly, subject to additional resources.

In general, present state administrative data provide an insufficient basis for comprehensive policy decisions. Some data collected are required in any case to meet federal reporting standards. Data are needed to make policy decisions about allocating state resources and allocating aging resources appropriately.

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[123] Frank W. Neuhauser, Henry E. Brady, and Jason S. Seligman. *Planning for a Comprehensive Database on Aging Californians: Meeting Public Policy and Research Needs for Better Information*. Berkeley: California Policy Research Center, University of California, 2003. Get full report from the CPRC Website: http://www.ucop.edu/cprc/publist.html#AGING

The developers of a Comprehensive Database on Aging Californians must be aware at every step that data must include not only a sample of the population in programs, but also a sample of the entire over-60 population. Statistical inference to populations, the cornerstone of much policy analysis, is dependent on accurate estimates of the whole population. At least a sample of all Medicare/Medi-Cal and SSI support-payment histories should be constructed in the same fashion as the Long Term Care Integration Project (LTCIP) data to allow a fuller picture of service use, medical conditions and potential future needs of the entire aging population. Such a sample of the Medicare population should include a representative sample of all Californians over 65, since nearly this entire population cohort is eligible for Medicare.

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Health data is now centralized with appropriate privacy protections. Now consumers and their care providers can access the patient's complete medical history and avoid conflicting treatment regimens. Another benefit has been the ability to congregate this data and use it to track changing health patterns, treatment efficacy, epidemiological data, and other key health indicators.

There is an outstanding one-stop shopping information and referral system available that covers the entire spectrum of senior services, from volunteer opportunities to recreation to health care. This information is available free via the Internet on an accessible Website. It is also available in various languages spoken in California, and in Braille and audio formats.

Having built on existing data resources, the state's health and human service information infrastructure was expanded and integrated to establish effective and timely communication**:**

- Among health care and service providers
- Between consumers and health care and/or service providers
- For consumer information and referral
- For research and planning

DATA AND DATA SYSTEMS RECOMMENDATIONS

1. Subject to Funding, Create a Comprehensive/Integrated Database on Aging and Disabled Californians. From this base develop both a Care Navigation System and a Longitudinal Data Base for program and policy decision making

Step 1 – Appoint a lead agency to direct and coordinate the implementation of an integrated information system.

Step 2 – Develop an improved standardized minimum data set for each reporting entity from Planning and Service Areas (PSA) to nursing homes. Include disability and dementia data in order to fulfill Federal and State

requirements, while simultaneously supporting care navigation and the longitudinal database.

Step 3 – Develop Standard Definitions – Establish a team representing the range of long term care programs, public and private, to develop standard definitions for each data element to be collected across all sectors in California that provide services to the aging, persons with dementia and/or the disabled. Encourage collaboration with other data groups to keep abreast of other related efforts.

Step 4 – Conduct Gap Analysis building on the Neuhauser *et al* CPRC report,[124] determine and document what and where the data is and what data is needed.

Step 5 – Implement in Phases building on models supported by the Aging with Dignity Long Term Care Innovation Grants to expand integrated data strategies statewide.

2. Improve Data Collection Concurrent with the integrated database design:

a. Expand Long Term Care Integration Project (LTCIP) data linkage effort to include data from all counties. The sample used should be based on the same sample selection principle used in the original project.[125]

b. Build on the existing annual California Health Interview Survey (CHIS) by creating representative samples of subpopulations of cohorts 50 and over.

c. Collect Epidemiological Data to understand the relationship of disease patterns/health conditions to changing size and ethnic composition of California's aging population.[126]

d. Create demand estimates at the county level by using CDA service data in combination with CHIS, national Health & Retirement Survey (HRS), and census data.

e. Capture data on a 10% sample of client data from the gamut of long term care and service providers, including, but not limited to: Residential Care Facilities for the Elderly, Multipurpose Senior Services Program, Adults Day Services, Adult Day Healthcare Centers, Alzheimer's Day Care Resource Centers, and all home and community-based service providers.

f. Data should be collected and analyzed on the housing needs of the elderly in California, including the need for supportive housing and assisted living, the prevalence and need for affordable and/or subsidized housing among the elderly, and updated information on the characteristics of senior housing facilities and residents.

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[124] Frank Neuhauser, Henry Brady, Jason Seligman. *Planning for a Comprehensive Database on Aging Californians: Meeting Public Policy and research Needs for Better Information*. Berkeley: University of California, California Policy Research Center, 2003.

[125] Neuhauser, Brady, Seligman recommend that LTCIP data "should include a sample of all people over 60 receiving Medicare and /or Medi-Cal as well as MDS data from nursing homes." To ensure standard sample selection they give an example of "a 10% sample, based on the last digit of the Social Security number, would give us a consistent 10% sample across all proposed areas." P. 30

[126] Survey data should include changing patterns of health conditions such as diabetes, cancer, cardio vascular, dementia and related disorders, plus functional status, social support networks, caregiving responsibilities, insurance coverage and other key indicators.

g. Track the number of subsidized public housing units, including the number of those units that are occupied by people with and without disabilities, number of bedrooms and bathrooms in each unit, and any other data deemed relevant for planning purposes.

h. Conduct studies to better understand what service acceptability or appropriateness factors contribute to appropriate LTC service utilization, as well as what systems are needed to achieve this goal.[127]

3. Build Data Networks That Connect Home and Community-Based Providers and Hospitals.

a. A statewide coordinated project is needed to assist some local agencies in securing the hardware and software infrastructure to collect expanded data effectively in an integrated database.

4. Build and Implement a Care Navigation System [128]

a. Build a system that follows the consumer regardless of county/PSA residency. The system must allow an individual and care provider to "go through any door" to get information and access the long term care system, within the framework of HIPAA privacy protections. This should be a three-pronged system in conjunction with the "Comprehensive/Integrated Database" (1. above) and the existing CalCareNet system.

Part 1 – **Explore the Implementation of a California 211 Calling System** to connect families in need to the appropriate community-based organizations and government agencies. (At least 17 states have already signed up.)

Part 2 – Develop an Integrated, One-Stop Consumer Information System

1) Develop and implement a statewide, one-stop information and referral system that covers the spectrum of senior information and services from recreation, housing and jobs to healthcare and home support services. This system will help users choose the right type of care or supported living facility. Information would be available free via the Internet on an accessible Website and be translated into all languages spoken by more than 5% of the California population.

2) Expand the CalCareNet Web-Based Information and Assistance (I&A) portal.

3) Enhance and improve the user friendliness of CalCareNet. For example, consider the use of intuitive/illustrative icons similar to the American Automobile Association hotel guides, to describe the features of RCFEs or nursing homes. Include information on RCFE's having dementia waivers.

4) Provide direct web links to county/PSA-sponsored consumer information databases.

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[127] Charlene Harrington, Robert Newcomer, Patrick Fox, M. ChristineTonner, Valerie Wellin, Martin Kitchener. Publicly Financed Long term care Programs for the Aged in California. Berkeley: University of California – California Policy Research Center, 2001. Page 32.

[128] Care Navigation is required by in Senate Bill 953 (2002, Vasconcellos) – California Integrated Elder Care and Involvement Act

5) Increase public awareness of the site using various media such as printed advertisements inside vehicle registration packets or state tax forms and radio and television public service announcements..

6) Develop alternative distribution system to get information to persons unable to access or use the internet, such as an automated interactive telephone voice response system. Provide print information for a fee.

Part 3 – **Provide a secure mechanism** for physicians or persons qualified to work with consumers/ caregivers to use the system to communicate and/or coordinate needs and services, refer to and/or purchase services, and develop a plan of coordinated care.

1) Ensure that all HIPAA/privacy standards are met and enforced. Upon taking any plan to the development stage HIPAA must be consulted.

2) Consult with the Santa Barbara County Care Data Exchange (SBCCDE) demonstration project. [129]

5. Conduct a Bi-Annual Customer Survey on Community Service Providers

a. Convene a group of interested parties to explore the development and administration of this survey.

6. Allow External Research and Evaluation

a. Ensuring that all HIPAA/ privacy standards are met and enforced, use consumer/program data for all 58 counties through the development of a modified database with all personal identities removed.

2. PROVIDER WORKFORCE

BACKGROUND

Excerpts from reports by Andrew Scharlach, Jaimie L. Simon and Teresa S. Dal Santo [130]

Rapid increases in the size and diversity of the elderly population have prompted concerns regarding the adequacy of existing human and social resources for meeting the increasing demands of older people.

Increasing numbers of older adults have physical disabilities, cognitive impairments or mental illness. Of particular concern are the elderly with complex conditions marked by chronic physical or mental health problems, multiple simultaneous

[129] The SBCCDE project has been funded by the California Health Care Foundation since 1998 and is working out the legal, organizational, financial, technical, and operational mechanisms to foster health information exchange. The program operated as a public utility for the secure exchange of patient specific clinical information.

[130] Andrew Scharlach, Jaimie L. Simon and Teresa S. Dal Santo. *Social Workers In California's Public Services: Implications for State Policies and Programs* - Brief. Berkeley: California Policy Research Center, University of California, 2003

disease processes, and problematic personal, interpersonal, social, and economic situations. These complex conditions warrant:

- Comprehensive multidimensional assessments
- Coordination of care, including assistance accessing and paying for services
- Efforts to increase an individual's independence

These represent a combination of services often provided by social workers and typically described as case [or care] management.

Case management has been shown to be effective in helping disabled elderly individuals. Recipients are less likely to require institutional care, and often experience an improved quality of life. Case management also results in reduced strain among family caregivers.

Research suggests that case management is best provided by experienced professionals such as masters-trained social workers. Aging-services workers who lack professional training and skills may neglect essential aspects of assessment and case management, such as client self-determination and related ethical issues. These could result in poor planning for care.

Case management is particularly important for older adults who are victims of abuse and neglect. The 1998 passage of California Senate Bill 2199 (Ch. 946, Lockyer) introduced mandatory procedures for reporting elder abuse, resulting in an increased demand for county adult-protective services (APS) and requiring a near doubling of APS positions in some counties. Because social workers have had specific training regarding the assessment and treatment of resistant clients and pathological family dynamics, they are apt to be especially effective in responding to elder abuse and neglect.

Moreover, social workers have a set of distinct professional values and ethics, including mutual responsibility, confidentiality, and self-determination, that are essential for resolving the ethical challenges that are typically involved when the elderly face abuse, neglect, or other complex physical, psychological or social vulnerabilities.

A Critical Shortage?

Unfortunately, the existing workforce of social workers is inadequate to help the growing numbers of elderly people who need adult protective services or other types of case management. The National Institute on Aging estimates that 60,000 to 70,000 social workers are currently needed to provide services to older adults.

Furthermore, although more than half of the 155,000 members of the National Association of Social Workers indicate that gerontological knowledge is necessary in their positions, only about 5,000 members currently claim aging as their primary field of practice.

Future prospects do not look any better. Nationally, only about 3% of social-work students specialize in geriatric social work during their Master of Social Work (MSW) training, and only another 2% take any classes in social work with older adults. This lack of professionally trained social workers with gerontological knowledge and skills is apt to have a potentially negative impact on the ability of county governments and other providers of aging services to meet the needs of an aging society.

Need for Increased Numbers of Latino Social Workers

Fifty percent of aging services personnel were non-Hispanic whites, while the remaining personnel were distributed among other ethnic groups as follows: African American (14%), Asian American (13%), Hispanic (18%), Native American (<1%), Pacific Islander (2%), and other (2%). This distribution corresponds closely to the 2000 census figures on the racial and ethnic composition of the state's overall population for non-Hispanic whites, Asian Americans, and Pacific Islanders.

However, African Americans, who represent 6.2% of the state's population, were over represented in this sample, while Hispanics, who make up 28.1% of the general population, were underrepresented.

Lack of Educated and Trained Applicants

Lack of educated and trained applicants are key barriers to filling vacant health, mental health and social service positions. When asked to identify the greatest barriers to hiring aging-services personnel, 72% of respondents cited a lack of qualified and properly educated applicants; 70% cited inadequate salaries in aging services; 40% cited insufficient numbers of ethnically diverse applicants; 32% cited the high cost of living in the area; and 23% cited difficult working conditions.

The Role of Interpreters in Health Care Includes the Following: [131]

1. Provides a linguistic conversion from one language system into another in a way that meaning is preserved.
2. Imparts accuracy and completeness in interpretation.
3. Facilitates understanding and communication between people who speak different languages and acts in the interest of achieving the well-being of the patient.
4. Serves as a cultural bridge.
5. Promotes direct communication between patient and provider by maintaining transparency and making sure that both parties understand what was said when speaking in his/her own voice.
6. Performs only functions for which he/she has training and experience.
7. Does not speak for either the patient or the provider during the encounter and does not offer his/her own opinions of the patient's history, view or concerns.

[131] Putsch. Language Access in Healthcare: Domains, Strategies and Implications for Medical Education. Page 23.

THE VISION - In the Year 2020…

The health and social services workforce is now multilingual and multicultural. Basic education for physicians, nurses and other professionals now includes an excellent foundation in gerontology and/or geriatrics, and in delivering culturally and linguistically appropriate service. Continuing education courses in these topics keep professionals proficient and aware of new trends, treatment and services. The result is fewer missed diagnoses, symptoms are better understood and treatment plans consider all of the individual's conditions.

Seasoned professionals have taken advantage of incentives and are returning to school in order to specialize in geriatrics and gerontology in their fields.

Thanks to better compensation packages and successful career ladder programs, care and social service providers are available in appropriate numbers to staff acute care, facility-based and home care needs. Intensive recruitment efforts are successful and ongoing. Working conditions and safety have improved substantially. Turnover rates have stabilized at a low rate.

HEALTHCARE AND SERVICE PROVIDER WORKFORCE RECOMMENDATIONS

1. Understand and Address California's Health Care Workforce Deficit

a. Subject to the availability of resources, conduct organizational assessments of hospitals and community health and social service agencies on workforce issues. Project workforce gaps through at least 2030 in relation to the growing aging population. Develop and implement plans to address gaps.[132]

b. Subject to the availability of resources, maintain at least the present Nurse Workforce Initiative Phase I and II funding to provide 5,000 nurses. If new projections show more extreme shortages, extend the goal and add program funding in proportion to the need.

c. Subject to the availability of resources, assess the current medical practice environment and its effect on shortages in physician specialties,

d. Subject to the availability of resources, enhance greater use of telemedicine and physician assistants to help offset personnel shortages in rural areas.

e. Subject to the availability of resources, encourage and support state and local efforts, involving both the private and public sectors to explore use of business partnerships with individual employers or consortiums of employers, training providers and public agencies.[133]

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[132] Moore, Senator Richard T. *Massachusetts – A Caring Commonwealth.* The Healthcare Policy of Massachusetts. May 2003. Page 23.

[133] *The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation.* Washington, DC: A report to Congress prepared by staff from the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Medicare and Medicaid Services (CMS), Health Resources and Services Administration (HRSA), and for the Department of Labor's Office of the Assistant Secretary for Policy, Bureau of Labor Statistics (BLS) and Employment and Training Administration (ETA). May 14, 2003. Page 4.

2. Ensure Recruitment and Retention of Healthcare Professionals, Allied Health, Mental Health and Paraprofessionals [134]

a. Seek ways to broaden the supply of frontline workers by reaching out to older workers, former California Work Opportunities and Responsibility to Kids (Cal WORKS) program recipients, military personnel transitioning to civilian life, individuals with recent experience providing care for family members, dislocated workers from other industries and young people.[135]

b. Identify and share model recruiting and retention practices that are most effective in reducing staff turnover and in reducing incidents of occupational injuries/illness.

c. Develop a nursing career ladder program for certified nursing assistant (CNA) to licensed vocational nurse (LVN) to registered nurse (RN).

d. Expand opportunities for career ladder advancement through training programs for CNA's as Restorative Nurse Assistants (RNA), a specialty program.[136]

e. Examine working conditions for all of the care giving professions, for example:

1) Conduct surveys and focus groups to determine specific work conditions causing individuals to leave their jobs. [137]

f. Conduct a survey with each sector. Based on results, develop and implement recruitment and retention plans.

g. Subject to the availability of resources, provide incentives to existing health/social service professionals to get additional education in gerontology. Provide the highest incentives for those who will commit to working in underserved areas.

h. The health care industry should establish a standard format for exit interviews and share such findings through professional associations.

i. Evaluate recruitment and retention practices. Ensure ongoing success in attracting and selecting the highest quality staff by regularly monitoring and analyzing the effectiveness of outreach and intake methods, techniques, and survey instruments, including exit interviews.[138]

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[134] The Quest for Caregivers, Helping Seniors Age with Dignity. California Employment Development Department. April 2001, p. 22-1.

[135] The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation. Page 4.

[136] The EDD reports that the RNA was the most successful of the CNA career ladder model concepts developed the Quality Care Health Foundation (QCHF) in association with the California Association of Health Facilities (CAHF) with their California Training Initiative project funded by the Employment Development Department with Governor's Workforce Investment Act monies.

[137] Testimony Assembly Select Committee on California's Nursing Shortage, Assemblyman Paul Koretz, Chair. July 16, 2003. Feedback included concerns linked to day to day fluctuations in bed census, for example canceling staff shifts when census goes down and mandatory overtime when it goes up. Additional concerns are raised over reducing support staff when nursing ratios are lowered, loss of the 12-hour premium incentive, and being involved in problem solving.

[138] Kahn, *Recruiting Quality Healthcare Professionals*. Paraprofessional Healthcare Institute. August 2000, p. 16.

3. Enhance Workforce Quality By Requiring Core Competencies[139]

a. Support an interdisciplinary effort to develop a core set of geriatric competencies and a common language across the health, mental health and social service professions.

1) These should include patient-centered care, the bio/psycho/social needs of the aging, evidence-based practice, interdisciplinary teams, quality improvement and problem solving.

2) Train providers on core competencies in order to encourage patient-centered care

3) Core competencies should incorporate caring for people with dementia.

4. Ensure Adequacy of Provider Training/Education

a. Develop continuing education that covers: abuse detection, unique issues of aging, alcohol and medication misuse, community based care, home care, nursing home care, rehabilitative care, palliative care and care at the end of life.

b. Promote training requirements in dementia issues for health professionals and other persons who are likely to be interacting with or providing care to persons with Alzheimer's. These professionals include but are not limited to, mental health professionals, residential facility and personnel (including assisted living and skilled nursing), and emergency room and other in-patient hospital staff.

c. As many older adults may also have disabilities, training should integrate elements including: Disability Awareness, Disability Etiquette, Disability Access and Independent Living Philosophy.

d. Integrate fall prevention training into continuing education for physicians, health and social service professionals.

3. HIGHER EDUCATION

BACKGROUND [140]

California will soon confront a larger older population and smaller younger working-age population, making it difficult to sustain our current policy and programs. This shift brings an increased demand for professionals with knowledge of and expertise in the human aging process. "Both childhood and 'seniorhood' are distinct developmental stages with unique challenges and tasks."[141] Those who work with these distinct populations need specific education and knowledge to effectively meet the challenges.

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[139] *Health Professions Education: A Bridge to Quality*. Institute of Medicine Report, 2003, p. 6

[140] Excerpts from testimony to the Informational Hearing of the Senate Subcommittee on Aging and Long Term Care and the Assembly Committee on Aging and Long Term Care. *Education for Professions in Aging: Issues and Recommendations,* February 18, 2003.

[141] Barbara Gillogly, Ph.D. Director, Gerontology, American River College. Excerpts from presentation, *Gerontological Education and the Community College* Delivered to the Senate Subcommittee on Aging and Long Term Care and the Assembly Committee on Aging and Long Term Care. February 18, 2003.

At present, California faces a severe shortage of professionals and paraprofessionals needed to operate programs and provide services for older adults. For example: [142]

- There are approximately 890 geriatricians in California, only one geriatrician per 4,000 Californians 65 years of age or older.
- There is a shortfall of approximately 30,000 certified nurses aids needed to provide care for frail seniors who reside in nursing homes.
- California ranks 50th in the ratio of employed registered nurses (RNs) to its population[143] and very few have obtained credentials as gerontological nurse specialists.[144]
- 20% of the Medical Service Study Areas in California are below the Dental Health Professional Shortage Area ratio of primary care dentists-to-population, with 68% of these shortages in rural areas. Moreover, of the 32 areas that have no dentists, 31 are rural.[145]

The majority of those now working with seniors, and those designing and administering programs and funds, have hands-on experience, but no formal education in gerontology. As the complexity and urgency of these senior programs increase, so does the need for trained professionals who are knowledgeable about senior issues and the societal impact of the rapidly growing aging population. "Now is the time for California to validate the importance of gerontology education." [146]

Nurses are a high priority. Without additional qualified faculty and other resources, nursing schools will not be able to educate enough additional nurses to maintain current ratios, and consequently will not be able to provide qualified nurses in response to the increased demand of an aging society.[147]

The California population is also one of the most culturally diverse in the nation. Currently, 27% of Californians over 65 years of age are non-white, climbing to 35% by 2010. All non-white ethnic groups now comprise the majority of California's overall population, with Latinos becoming the dominant population group over the next 40 years, projected to be 48% of the state's population by 2040.[148] This fact

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[142] Janet C. Frank, Dr. P.H., MS in Gerontology, testimony to Senate/Assembly Hearing on Aging/Long term Care, February 18, 2003

[143] Center for Health Workforce Studies, School of Public Health, University at Albany, State University of New York. HRSA State Health Workforce Profiles: California. US Department of Health and Human Services (USDHHS), HRSA, Bureau of Health Professions (BHPr), National Center for Health Workforce Information & Analysis. Rockville, MD: December 2000.

[144] P. Rosenfeld M. Bottrell, T. Fullmer, *et al. Gerontological nursing content in baccalaureate nursing programs: Findings from a national survey*. Journal of Professional Nursing. 1999, 15{2):84- 4.

[145] Center for Health Workforce Studies

[146] Gillogly testimony, Senate/Assembly Hearing on Aging/Long term Care, February 18, 2003.

[147] J. Coffman, J. Spetz. "Maintaining an adequate supply of RNs in California". Image: Journal of Nursing Scholarship. 31 {4):389-393. Fourth Quarter 1999.

[148] O'Hara-Devereaux M, Falcon R, Dong Xiu Li J, Kristensen H. *Fault Lines in the Shifting Landscape: The Future of Growing Older in California-2010.* Institute for the Future. Report prepared for the Archstone Foundation. Menlo Park, CA: November 1999.

calls for preparation in both gerontology and cultural proficiency for future health and social service professionals.[149]

"It is in the best interest of the entire California populace, not only our elderly, to seize these opportunities for change to mitigate the current shortcomings, which are fast reaching critical proportions." [150]

THE VISION - In the year 2020…

The field of geriatrics has risen in stature among the medical specialties, partially due to the enormous demand, partially due to financial incentives offered by public and private universities and colleges, and also due to the reversal of discriminatory reimbursement rates for geriatricians. Even so, more health care professionals with training in geriatrics and gerontology are needed.

Special incentives are directing professionals to underserved areas. These have substantially increased health access in rural and inner city communities.

There has been a dramatic increase in health professionals' early recognition of mental illness, cognitive impairment and alcohol/chemical dependency in the older population. This happened as a result of the state's targeted continuing education and certification requirements for health and mental health professionals, including emergency medical staff, family physicians and internists. Because conditions are being recognized, early treatment frequently prevents or slows disease progression.

Public and private universities and colleges offer financial incentives for entering the health professions with additional incentives offered for geriatrics and gerontology programs. Extra incentives are also offered for serving after graduation or certification in underserved areas. This extra help has substantially increased health access in rural and inner city communities.

In addition to health care the California State University and University of California systems are supporting older adults with educational programs. The University of California's Renaissance Society programs and UC and CSU Extension cultural enrichment and professional certification courses have added significantly to the older adults employability and to the quality of their lives.

The results of this life long learning approach can be seen in how well prepared current retirees are for their retirement years - economically, socially and psychologically.

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[149] Janet C. Frank, Dr. P.H.

[150] Excerpts from *Education for Professions in Aging: Issues and Recommendations*. Senate/Assembly Hearing on Aging/Long term Care, February 18, 2003.

HIGHER EDUCATION RECOMMENDATIONS

HEALTH AND HUMAN SERVICES WORKFORCE

1. UC/CSU and Other Private College and University Programs should:

a. Raise the stature of the field of geriatrics so that it becomes as prestigious a medical specialty as pediatrics. [151]

1) Create a cadre of academic geriatricians who will educate all doctors in the care of older people.

2) Expand academic programs in geriatrics at medical schools, with authority equivalent to full academic departments, which assures curriculum time and requisite resources.

3) Subject to the availability of resources, increase funding for academic geriatrician and gerontology development programs through the state higher education system.

4) Expand geriatric curriculum in Pharmacy programs

5) In conjunction with medical and pharmacy schools, professional medical associations should be encouraged to collaborate to publish a health newsletter on geriatrics, such as *Health Notes* published by UCLA with the California Association of Pharmacy.

6) Develop special state-supported fellowship, training and continuing educational programs in geriatrics and gerontology. Such programs could be included in an expanded Academic Geriatric Resource Program.

7) Study and replicate best practices in the most highly respected public and private academic geriatric programs.

b. Reinvigorate the core geriatrics curriculum to expand beyond disease management and the curative process to include prevention, the management of chronic conditions, pain management and end of life care.

1) Require ongoing continuing education in long term care with an emphasis on community-based care.

c. Encourage geriatrics and gerontology studies in every curriculum regardless of specialty. Encourage all physicians, nurses, pharmacists and other health-care professionals to know how to care for older patients, including patients with dementia. For example:

1) Train all primary care, specialty physicians and pharmacists in geriatrics.

2) Integrate geriatrics into every subject in medical school curricula.

3) Require medical students, interns and residents to rotate through the continuum-of-care for aging patients, including hospital care, rehabilitative care, home care, nursing home care, palliative care and care at the end of life.

[151] Butler, A. National Crisis: The Need for Geriatrics Faculty Training and Development Toward Functional Independence in Old Age. New York: The International Longevity Center, 2001. Page 10.

2. Community College Nursing Programs should: [152]

a. Establish consistent guidelines for admission policies, including prerequisite requirements and methods for allocating slots in oversubscribed programs, to create a clear statewide admission practice.

1) The development of these guidelines should be a collaborative effort of the State's nursing programs, with guidance and coordination from the California Community College Chancellor's Office.

b. Offer English as a Second Language, remedial support services and tutoring programs. A component of instruction should include a course on medical terminology for limited English proficient students.

c. Establish a support program for nurses at all levels to support the education of nursing staff, from nurse assistants to nursing faculty.[153]

1) Support would include scholarships, childcare, housing grants and mentorships in order to increase probability of success.

3. Significantly Increase Resources for Nursing, Allied Health, Mental Health and Paraprofessional Programs

a. Subject to the availability of resources, develop a reimbursement system that funds critical educational needs according to the cost of and demand for the program, thereby removing administrative disincentives for expanding nursing programs,

b. Target funding increases in order to:

1) Develop new gerontology instructional programs and increase access to existing programs

- Subject to the availability of resources, colleges and universities need to look at the issue of aging across the board. Consider the number of practitioners needed and the need for other professionals to have exposure to aging (e.g., media, marketing, community planning, transportation planning, etc.)
- Raise the status of gerontology to that of other health and human service professions
- Partner with organizations that have respected training programs on working with older persons

2) Increase enrollment capacity of existing nursing and allied health educational programs. [154]

3) Attract more nursing faculty by raising wages to be at least equal to the professions they are educating.

4) Subject to the availability of resources, provide multicultural support for students - All learning institutions should provide specific training and services to faculty and students to support the efforts of students from all cultural and ethnic groups.

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[152] Most community college nursing recommendations came from the California Post Secondary Education Commission (CPEC) Report 03-2, *Admission Policies and Attrition Rates in California Community College Nursing Programs*, page viii.

[153] Moore, Massachusetts – A Caring Commonwealth. Page 22.

[154] Moore, Massachusetts – A Caring Commonwealth. Page 22

- Training may include communication across cultures, strategies for identifying students who are having difficulty, English skills, counseling and mentoring techniques, and unbiased course material and tests.
- Provide tutoring services in English as a second language to nursing students requiring such assistance.

c. Develop a plan to increase the number of health facility partners for nursing schools to ensure breadth and depth of student experience.

1) Establish Regional Collaborative Partnerships for training and preceptorship positions in hospitals, community colleges and/or the CSU system.

4. Student Recruitment

a. In addition to traditional recruitment programs, develop outreach recruitment programs customized to target groups.

1) Customize recruiting efforts to increase diversity.
2) Target recruiting efforts towards men as well as women.

b. Subject to the availability of resources, encourage student enrollment in health care fields by providing special financial incentives for those who choose and successfully achieve health care careers.[155]

c. Subject to the availability of resources, increase the amount of need-based financial aid available to nursing students, so that fewer students have to work to support their studies.[156]

d. Subject to the availability of resources, establish a One-Stop Web-Based Education Information System where prospective students can access all state colleges and universities.

1) Potential uses of such a Website would include, but not be limited to, information on individual institutions, programs offered, fees/tuition, enrollment requirements, available seats, the ability to request information and start the application process.

e. Outreach to high schools

1) Establish a statewide initiative to educate junior high and high school students about careers in health care and social services related to aging in order to promote a broader interest in these fields.[157] Include information about the variety of careers and what high school classes and preparations are necessary.

5. Hold a Biennial Interdisciplinary Summit[158]

a. Subject to the availability of resources, hold a biennial interdisciplinary summit involving health and human service leaders in education, oversight processes, practice and other related areas. This process should focus on both reviewing progress against explicit targets and setting goals for the next phase with regard

[155] Moore, Massachusetts – A Caring Commonwealth. Page 23
[156] CPEC Report 03-2. Page ix.
[157] Moore, Massachusetts – A Caring Commonwealth. Page 23
[158] Health Professions Education: A Bridge to Quality Institute of Medicine Report. June 2002. Page 2.

to the five competencies and other areas necessary to prepare professionals for the 21st-century health and long term care system.[159]

THE ROLE OF HIGHER EDUCATION IN THE AGING INFRASTRUCTURE

1. Conduct Research to Expand Knowledge Related to Aging

a. Higher education should be integrally involved in on-going data collection and analysis related to an aging population.

1) Monitor the effectiveness of data collection strategies and their implementation.

2) Examine policy implications as the boomers enter and exit the aging cycle.

3) Monitor changes in projected service utilization.

4) Conduct on-going research related to physiology of aging to establish new theoretical models.

5) Continue to examine aging socio-demographic changes and the impacts on housing, transportation, meals programs, home support, health care and supportive services for community based living.

6) Communicate findings with local service providers and non-profit agencies, in order to further develop networks of care.

2. Develop Guidelines for Individuals to Work with Older Adults [160]

a. Because higher education has a responsibility to produce a well-informed workforce on aging, the California Council on Gerontology and Geriatrics (CCGG) recommends the implementation and monitoring of guidelines and recommendations for those who work with, for and on behalf of older adults.

b. Assist educational system with goals and implementation: Work with UC and CSU system to explore the need for Gerontology *Centers of Excellence* in the Northern and Southern regions of the state. (Specific course content has been outlined based upon the Standards and Guidelines of Curriculum from the Association of Gerontology in Higher Education.)

1) Provide gerontological content in specific disciplines of human and social services through continuing education and academic degree programs,

2) Continue introducing geriatric education throughout the curriculum through the work of Geriatric Education Centers and continuing medical education (CME) requirements.

3) Long Term Care administrators' requirements for aging-related continuing education needs to be consistent across all disciplines associated with older adults.

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[159] The California GEC is funded to do "key educational stakeholders" meetings annually and may be a venue for interdisciplinary programs and a foci for geriatric education centers of excellence. The California GEC and the new NorCal GEC at University of California at San Francisco involves community, University of California and California State University institutions in their consortia.

[160] Excepts from the presentation by the California Council of Gerontology and Geriatrics at legislative hearings from l999-2003.

3. Retraining and Retooling Skills

a. In order to support older individuals moving into new career options, higher education should provide skill development and upgrade existing skills as technology continues to move forward.

4. Ensure Educational Opportunities to Maintain an Informed Citizenry

a. Campuses should consider more formal support for existing senior learning groups that are peripheral to the institution, that exist as emeritus groups or are available through extended education.

1) Be flexible enough to "go where the need is" in the community.
2) Help redefine expectations, behavior and norms across the life span.

5. Higher Education Should Take a Leading Role

a. Redefine aging by working to eliminate stereotypes, identifying alternative life opportunities, and helping people to prepare for them.

b. Expand new knowledge related to all aspects of aging.

c. Broadly implement a certificate program that serves as a starting point for higher level opportunities.

d. Support older adults' productive roles in society and their opportunities to continue to make significant contributions.

4. HOSPITALS AND CLINICS

THE VISION - In the Year 2020…

The resurgence of health planning has enabled community leaders and medical facility administrators to have solid data upon which to make supply decisions regarding primary facility and acute care bed demand. This has been particularly welcome in rural areas where data supported the construction of numerous small clinics staffed primarily by nurses and nurse practitioners connected electronically to physician specialists located in medical centers and teaching hospitals.

Since Californians enjoy expanded health care coverage, incentives have been realigned to support more cost effective alternatives to emergency room care.

HOSPITALS AND COMMUNITY CLINIC RECOMMENDATIONS

1. Explore Funding Mechanisms for Indigent Care to Stop Acute Care Bed Loss and Emergency Room Closures

a. Analyze and determine the overall cost/benefit of reduced state and local appropriations to public hospitals, health systems and community clinics.

1) Focus on demand for emergency services and the human and economic consequence of shortages.[161]
2) Focus on the economic impact on the private acute care system, including the consequences of emergency room closures.

2. Determine Local Demand for Hospitals, Emergency Rooms and Clinics

a. Develop a formula and process to develop demand data for acute care beds, emergency room capacity and community clinic capacity throughout California.
b. Give priority to needs analysis in high-density urban and low-density rural areas.

5. TECHNOLOGY/ASSISTIVE TECHNOLOGY

THE VISION - In the Year 2020…

The technology boom continues to bring ever-increasing advantages to seniors' lives. Foundation research grants supplied needed capital to develop innovative helpful products. Health plans now address *functional* necessity and offer home assessments so seniors receive guidance as to what technology is appropriate for them.

Residents of the rural areas of California have also benefited by the technology boom. Thanks to wireless communication telemedicine has been a mainstay for years. Physician assistants and nurse practitioners staff the telemedicine centers and provide the high touch link between physician and patient. Quarterly *Outcome Reports* reveal very positive health outcomes, due in part to widespread geriatric training for all heath professionals, including training on new technology, and also due to strict quality assurance monitoring for all remote healthcare access programs in the state.

TECHNOLOGY/ASSITIVE TECHNOLOGY RECOMMENDATIONS

1. Support the Increased Use of High Tech to Improve Access to Healthcare

a. Subject to the availability of funding, increase resources to expand telemedicine services to serve persons isolated from health care facilities. Examples include persons with disabilities and those living in rural areas.

[161] Edward Newton, MD in "Emergency System Needs Transfusion," Los Angeles Times, March 16, 2002, writes: "Emergency Room physicians are required by law to examine and, when necessary, stabilize every patient who comes through the door without regard for that patient's ability to pay. Once a medically indigent patient can be transferred they must be sent to a public or private hospital for care. No other specialty has such an unfounded mandate."

1) Provide incentives for telecommunication companies who provide digital service to remote regions of the state.
2) Advocate for Medicare reimbursement of telemedicine services, especially for mental health.
3) Develop health policy that will pave the way for technology-based solutions to grow where they are cost effective, valued and necessary to improving community health.

b. Link CalCareNet to computerized health risk screening stations (Kiosks) in places where the lowest income seniors are likely to congregate or visit. Services should include screening for blood pressure/hypertension, asthma, diabetes, and calculation of health risk.

2. Support Greater Understanding of and Access to Assistive Technology

a. Expand programs to educate seniors and persons with disabilities on what assistive technology is, how it helps, how much it costs and where to get it, from high tech to low tech.
1) Provide information about assistive technology on the One-Stop Information Systems, CalCareNet and kiosks.

b. Provide individual counseling on appropriate assistive technology.

c. Develop incentives to expand research on and access to assistive technology.

d. Aging providers should link the federally funded California Assistive Technology (AT) Network for information and assistance (www.atnet.org) to all of their Websites and promote this site to older adults.

e. The Area Agencies on Aging (AAA) should be encouraged have AT Advocates that focus on AT for older adults, as the independent living centers (ILC) do for persons with disabilities.[162] The AAA should collaborate with the ILCs on this critical service.

[162] AT Advocates do outreach to under- and un-served populations to provide information about assistive technology; where to find it, how to go about getting it and sources of local funding. They can also provide training and information plus some service coordination for consumers who need that assistance.

III. IN CONCLUSION – Top 15 Priorities and Next Steps

This Plan attempts to encompass person-centered ideals. To this end, and with substantial input from consumers and other stakeholders, this plan has embraced these values:

- Individual Dignity
- Security, Protection
- Inclusivity, Diversity and Equity
- Choice
- Accessible Information
- Accessible, Visitable Housing
- Mobility
- Enrichment
- Education
- Prevention
- Adequate Service Capacity
- Collaboration, Integration

HIGHEST PRIORITIES

The Plan Development Task Team suggests, that of the many high priority recommendations set forth in this Plan, the following are most urgent. The urgency is due to their impact on older adults, the long lead-time required to complete implementation, and the critical path some of these recommendations play in the course of achieving other goals. Appendix E suggests timelines for these fifteen imperatives:

1. Greatly expand health insurance coverage
2. Provide education/training to develop or enhance skills so older adults can move into second career options
3. Build a comprehensive, integrated data base on aging and disabled Californians for longitudinal studies and care navigation
4. Address California's health and social services workforce deficit. Ensure the recruitment and retention of health care professionals, allied health, mental health and paraprofessionals
5. Provide a full continuum of transit services for seniors and persons with disabilities.
6. Amend the State Transportation Development Act and related regulations to ensure that all unmet transit needs in rural areas that are reasonable to meet are adequately identified and addressed.
7. Expand Smart Growth models of housing and land use that incorporate livable, walkable, mixed-use, intergenerational components
8. Strengthen support for repairs and home modifications by community-based organizations in every county
9. Expand the Preventive Health Care for the Aging (PHCA) program as an investment that avoids even more costly acute, primary care and long term support expenditures.
10. Greatly expand health care access in rural areas
11. In every county expand community-based mental health promotion, recovery, education and outreach for older adults; identify and incorporate mental health prevention best practices
12. Build and implement a "no wrong door" care navigation system

13. Build capacity into community-based long term support services to prevent unnecessary institutionalization
14. Develop and expand comprehensive, integrated care models
15. Develop a collaborative process to eliminate fragmentation, integrate funding, and create a customer-centered, seamless system of long term support

PLAN UPDATES

The legislation calls for periodic updates. No first writing of a strategic plan this broad can possibly cover all of the important issues and some may have inadvertently been left unaddressed. It is essential, therefore, that this Plan be continuously updated and improved and treated as a "living document."

The California Commission on Aging has agreed to assume responsibility for the monitoring and updating the Plan. In this capacity, the Commission shall convene stakeholders, hold meetings, and monitor the progress of priority action items outlined in the Plan. The Commission will 1) report to the Legislature the progress of the Plan's implementation, and 2) will update the Plan's contents to reflect changing priorities and actions. Reports to the Legislature will be on a bi-annual basis, with the first update to be in 2004, one year from the completion of this plan.

NEXT STEPS

It is now up to every organization that works with or on behalf of older adults throughout California to study this plan and determine what they can contribute toward its implementation. Leadership must emerge for every Plan element. Simultaneously, collaborative relationships must be developed across Plan elements. These actions will lead to meaningful implementation. With participation and collaboration from all sectors and with the state in the role of convener, this plan can move forward… one step at a time from any and every sector.

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EPILOGUE

An Attitude Shift – The Future

In the year 2020… healthier lifestyles and a positive attitude toward aging has given older adults more self-esteem and self-assurance, and is creating a positive self-fulfilling prophecy.

Advertisers reshaped their thinking and discovered the value of the over-50 market. The media have become pro-active partners in social marketing. Advertising

campaigns, television programming, movies and other forms of entertainment encourage personal habits and practices that promote improved quality of life. Storylines focus on older adults in non-stereotypical roles that celebrate a range of ages.

The broad availability of information in a variety of media enables individuals to have enough knowledge to plan realistically for their future.

Leaders and decision makers from business, government and non-profit organizations are working together to ensure that older adults have the opportunities they wish and the help they need. There is a palpable shift in attitude from “doing things on our own“ to a genuine sense of community – “we’re all in this together.” Older adults are helping each other.